CALIFORNIA PATIENT DISCHARGE DATA REPORTING MANUAL

Third Edition

OFFICE OF STATEWIDE
HEALTH PLANNING AND DEVELOPMENT

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For Discharge Data for the Years 1999 and 2000
June 2000

NOTICE

This **California Patient Discharge Data Reporting Manual, Third Edition**, issued May 2000, supersedes and replaces all previous versions.

This Manual consists of discussion and comments related to the regulations. In the case of any perceived conflict between the non-regulatory material in this Manual and any regulation, the regulation shall prevail.

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INTRODUCTION

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1. History of the Patient Discharge Data Program

Hospital uniform accounting and reporting began with the passage of the California Hospital Disclosure Act by the California Legislature, Senate Bill 283. It was signed into law by then Governor Ronald Reagan on October 26, 1971. The act created the California Hospital Commission (Commission) and gave it the mandated broad authority to set standards for hospital uniform accounting and reporting to enable the public, third-party payers, and other interested parties to study and analyze the financial aspects of hospitals in California. Through regulations adopted by the Commission on March 17, 1973, pursuant to the Hospital Disclosure Act, hospital data collection began for all fiscal years starting on or after July 1, 1974.

In 1974, legislation was enacted that expanded the Commission's jurisdiction and mandated the development of a uniform accounting and reporting system for long-term care facilities. The Commission was renamed the California Health Facilities Commission to reflect its broadened responsibilities. Pursuant to this legislation and implementing regulations, long-term care data collection began for fiscal years starting on or after January 1, 1977.

In 1980, the Commission's legislative mandate was again expanded. Senate Bill 1370 (Chapter 594, Statutes of 1980) added the following responsibilities: (1) collection of quarterly financial and utilization data to assess the success of the hospital industry's voluntary effort to contain costs, (2) integration of the Commission's long-term care disclosure report with the Medi-Cal cost report to reduce the reporting burden on health facilities, and (3) collection of twelve discharge data elements on hospital patients to provide greater understanding of the characteristics of care rendered by hospitals.

In June of 1982, the Commission's responsibilities for the collection of discharge data were expanded through passage of Assembly Bill 3480 (Chapter 329, Statutes of 1982). The number of discharge data elements to be collected by the hospitals, beginning January 1, 1983, were increased to fifteen, with the addition of total charges, other diagnoses, other procedures and dates, and date of principal procedure. Also beginning January 1, 1983, hospitals were given the option to report Abstract Record Number. Chapter 329 also scheduled all provisions of the Health Facilities Disclosure Act to sunset on January 1, 1986, unless extended by subsequent legislation.

During the 1983-84 legislative session, Senate Bill 181 was passed by the California Legislature and signed into law (Chapter 1326, Statutes of 1984) by then Governor George Deukmejian. This law, known as the Health Data and Advisory Council Consolidation Act, recognized that the California Health Facilities Commission would sunset on January 1, 1986, and transferred its functions to the Office of Statewide Health Planning and Development (OSHPD) on that date. Additionally, this bill eliminated the State Advisory Health Council

effective January 1, 1986, and formed a new advisory body called the California Health Policy and Data Advisory Commission (CHPDAC).

The mission of OSHPD is to plan for and support a healthcare system which meets the current and future healthcare needs of the people of California. To achieve this mission, OSHPD:

- Identifies the healthcare needs of Californians and plans how those needs can be met.
- Works with other entities to ensure that identified needs for healthcare professionals and facilities can be met.
- Tests and evaluates alternative concepts for healthcare professionals and settings.
- Ensures that health facilities are safe for patients and available to provide care to the community in the event of a major disaster.
- Provides information about facilities' finances, services, and patients to healthcare observers and decision makers.

With respect to this latter activity, OSHPD maintains several health facility information programs relating to hospitals, long-term care facilities, licensed clinics, and home health agencies.

OSHPD makes this information available to the public in order to promote informed decision-making in today's healthcare marketplace, to assess the effectiveness of California's healthcare systems, and to support statewide health policy development and evaluation.

The Patient Discharge Data Section (PDDS) of OSHPD is responsible for collecting data on all inpatients discharged from all licensed hospitals in California, correcting errors it finds in the data, and making the data available to the public through standard publications and electronic data files.

Assembly Bill 2011 (Chapter 1021, Statutes of 1985) brought additional refinement to the reporting and collection of hospital discharge data. It required hospitals to submit discharge data semiannually, not later than six months after the end of each semiannual period commencing six months after January 1, 1986.

In September of 1988, Senate Bill 2398 (Chapter 1140, Statutes of 1988), added two data elements: External Cause of Injury and Patient Social Security Number, bringing the number of mandatory data elements to seventeen. Through regulation, these additions were made effective with discharges on July 1, 1990, and thereafter.

Assembly Bill 3639 (Chapter 1063, Statutes of 1994) added the data element Prehospital Care and Resuscitation, if any, including "Do Not Resuscitate" (DNR) orders at admission or after admission. Other data elements added at that time were indicators for whether or not conditions were present at admission for both the principal diagnosis and other diagnoses.

Regulations required reporting of whether or not the conditions were present at admission for the principal and other diagnoses effective with discharges on or after January 1, 1996, and require reporting of Prehospital Care and Resuscitation with discharges on or after January 1, 1999.

The 1999 discharge data set includes the following eighteen data elements (in alphabetical order):

Admission Date
Date of Birth
Discharge Date
Disposition of Patient
Expected Source of Payment
External Cause of Injury and Other E-Codes
Other Diagnoses and Whether the Conditions were Present at Admission
Other Procedures and Dates
Patient Social Security Number
Prehospital Care and Resuscitation (DNR – Do Not Resuscitate)
Principal Diagnosis and Whether the Condition was Present at Admission
Principal Procedure and Date
Race
Sex
Source of Admission
Total Charges
Type of Admission
ZIP Code

Additional Reporting Requirements

The hospital has the option to include the Abstract Record Number for use by OSHPD and the reporting hospital to identify specific records for correction. If submitted, the abstract record number is deleted prior to release of public data.

The Hospital Identification Number (HIN) is a required part of the discharge data record. Using the reported data elements, OSHPD computes and adds to the discharge data record the appropriate Diagnosis Related Group (DRG) and Major Diagnostic Category (MDC), using the current version of the Grouper approved by the Federal Healthcare Financing Administration (HCFA).

Type of Care is also a required part of the discharge record. Type of Care may be one of the following: Acute Care, Chemical Dependency Recovery Care, Psychiatric Care, Physical Rehabilitation Care, or Skilled Nursing/Intermediate Care.

Senate Bill 1973 (Chapter 73, Statutes of 1998), as it pertains to the Patient Discharge Data Program, in part:

- requires that OSHPD, based upon review and recommendations of CHPDAC and its appropriate committees, allows and provides for additions or deletions to certain patient level data required to be reported.
- requires that after January 1, 2002, a hospital file an Emergency Care Data Record for each patient encounter in a hospital emergency department, and a hospital and freestanding ambulatory surgery clinic file an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed.
- establishes the time and manner in which the records are required to be filed with OSHPD and revises the time and manner in which health facilities are required to file Hospital Discharge Abstract Data Records with OSHPD.

2. Overview of Reporting Requirements

Pursuant to Subdivision (g) of Section 128735, California Health and Safety Code, hospitals are required to report eighteen data elements for each inpatient discharged from the hospital. Hospitals are defined in Subsection (c) of Section 128700, California Health and Safety Code. Because this reporting requirement is based on the hospital's license, the reporting requirement covers every patient discharged from a bed appearing on the hospital's license. Federal hospitals (operated by the Veterans Administration, the Department of Defense, or the Public Health Service) are not required to report because they are not subject to state licensure.

Discharge data may be submitted on OSHPD's Manual Abstract Reporting Form (OSHPD 1370) or on computer media. The required data must be filed semiannually, no later than six months after the close of the calendar semiannual reporting period.

Pursuant to Subsection (a) of Section 128700, California Health and Safety Code, there is a civil penalty of one hundred dollars ($100) a day for each day the filing of the discharge data is delayed. For purposes of initial submission of data or for correction of data, a hospital may request an extension of the reporting due date. A maximum of 60 extension days per reporting period may be granted.

Hospitals have the option of either submitting discharge data directly to OSHPD or designating an outside agent (abstractor or data processing firm) to do so on their behalf. If a hospital designates an agent to provide the data, it remains the responsibility of the hospital to make sure that its discharge data are filed by the due date and all reporting requirements are met.

3. How OSHPD Processes and Edits Discharge Data

The Manual Abstract Reporting Forms (OSHPD 1370) and computer media are submitted directly by hospitals or through designated agents. The PDDS activity desk analyst receives these data, verifies the transmittal information and either accepts or rejects the data. A delinquency notice is sent to the hospital if the data are not postmarked by the due date. A penalty notice is sent to the hospital once the data are received but not postmarked by the due date. Computer media are sent to OSHPD's Information Systems Section (ISS) to be added to OSHPD's database. The Manual Abstract Reporting Forms (OSHPD 1370) are key entered prior to being added to OSHPD's database. Edits are then applied to the discharge data. Actual computer processing is done at the California Health and Human Services Agency Data Center (formerly the State's Health and Welfare Data Center).

During the process of adding the data to the database, any record with discharge dates that are either invalid or fall outside the specified reporting period dates are not added. As a final step during the add process, the HCFA Grouper version appropriate to the proceeding October 1 is applied to each discharge data record.

Upon completion of the add process, the following reports are generated: Add Process Report (shows the number of records added to OSHPD's database and the number of records with discharge dates outside the current report period), Records with Invalid Discharge Dates, MDC/DRG Grouper Statistics, Questionable DRG Records (DRGs 468, 469, 476, and 477), and E-code Report.

Edit programs are then applied to each record, editing for errors and for consistency among data elements within each discharge data record. The edit programs apply field and relational editing criteria, which are described in the Editing Criteria Handbook. After the edits are applied, additional reports are generated: Data Distribution, Edit Summary and Detail, Listing of Blank and Invalid SSNs, Readmissions Summary and Detail Report, and Coding Edit Summary and Detail.

The review analyst reviews the above named reports, and through trend analysis, compares the hospital's discharge data to historical data and licensing information. If manual correction of the data errors is not feasible, the analyst may require the hospital to replace the data. After replacement data are received, the entire process is repeated.

The analyst may mail or fax to the hospital its reports of individual discharge data records for review and correction. If the request for corrections is by mail, the analyst will establish the date the corrections must be returned. The analyst will not change the data submitted by a hospital without the hospital's concurrence, except in the case of applying default values as specified in Section 97242, California Code of Regulations. Corrections received from the hospital are applied to OSHPD's database and new Data Distribution, Edit Summary, and Edit Detail Reports are generated. The analyst reviews the updated reports.

When corrections are completed, an Individual Hospital Discharge Data Summary (IHDDS) is produced, and the hospital's data are made available to the public in various forms. Hospitals may request one complimentary copy of their IHDDS from PDDS.

4. Availability of Discharge Data

Discharge data are available for purchase through OSHPD's Healthcare Information Resource Center at (916) 322-2814. The data are available in a variety of media and formats, including computer tape (reel or cartridge) and CD-ROM.

In order to protect patient confidentiality, data elements that may enable identification of an individual are masked before release to the public. Custom reports are available upon requests.

The OSHPD website at www.oshpd.state.ca.us has a variety of data files available for download at no charge.

REPORTING REQUIREMENTS

NOTE: **The regulations are identified by bold and italics.**

The section number located at the top right corner of the first page of each regulation refers to the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8.

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NOTICE OF CHANGE IN HOSPITAL OPERATIONS, CONTACT PERSON, METHOD OF SUBMISSION OR DESIGNATED AGENT Section 97210

(a) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in the person designated as the patient discharge contact person or in the telephone number of the contact person.

DISCUSSION

The person in the hospital who is designated to be the contact person for discharge data is usually the Medical Record Director/Health Information Manager. Some responsibilities of the discharge data contact person are to:

- respond appropriately to law, regulations, and notices from OSHPD that the discharge data are due. The hospital must meet that deadline, request an extension, or incur a civil penalty of $100 for every day the discharge data are late.
- respond appropriately to OSHPD's questions about errors in the discharge data, by coordinating replacement or correction of the data.
- assist the hospital in meeting its reporting obligations by directing OSHPD's requests for corrections to the appropriate department in the hospital and coordinating the hospital's response to OSHPD.

(b) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in method of submission or change in designated agent for the purpose of submitting the hospital's discharge data report. If there is a change in designated agent, the hospital or its new designated agent must comply with Section 97215. A hospital may submit its own discharge data report directly to the Office's Discharge Data Program, or it may designate an agent for this purpose.

DISCUSSION

Change in method of submission:

- Manual Abstract Reporting Form (OSHPD 1370) to computer media
- Tape to diskette or CD-ROM
- Diskette to tape or CD-ROM
- CD-ROM to tape or diskette

Change in designated agent refers to an entity that sends the data to OSHPD on behalf of the hospital.

(c) Each hospital beginning or resuming operations, whether in a newly constructed

facility or in an existing facility, shall notify the Office's Discharge Data Program within 30 days after its first day of operation of its: designated agent for the purpose of submitting the hospital's discharge data report (if it chooses not to submit its discharge data report directly), method of submission, contact person, and telephone number of contact person. The hospital shall be provided a unique identification number that it can report pursuant to Section 97239. Pursuant to Section 97215, the hospital, if it chooses to designate itself to submit its discharge data report, and its method of submission is not Manual Abstract Reporting Form (OSHPD 1370), shall submit a set of test data that is in compliance with the required format. Pursuant to Section 97215, any agent the hospital designates to submit its discharge data report on its behalf must have submitted a test set of data that is in compliance with the required format, prior to the due date of the hospital's first reporting period.

DISCUSSION

See Subsection (a) of Section 97210 for discussion of the contact person.

After OSHPD receives notification, the hospital will be notified of its unique HIN, as assigned by OSHPD, to be used on each discharge data record.

If the hospital elects to report its own discharge data generated by its in-house computer system, PDDS will provide the hospital with the standard format and specifications. Test data must be submitted by the hospital for approval by OSHPD before the next reporting period's due date. Additional test data information can be found on pages 17 and 18.

If the hospital reports using the Manual Abstract Reporting Form (OSHPD 1370), one copy of the form will be provided to the hospital by OSHPD in advance of the reporting period.

The Manual Abstract Reporting Form is available to download at no charge on the following website: www.oshpd.state.ca.us *This is a PDF file, which requires Adobe Acrobat Reader to view.*

REPORTING PERIODS AND DUE DATES — Section 97211

(a) The prescribed reporting period is calendar semiannual, which means that there are two reporting periods each year, consisting of discharges occurring January 1 through June 30 and discharges occurring July 1 through December 31. The prescribed due dates are six months after the end of each reporting period; thus, the due date for the January 1 through June 30 reporting period is December 31 of the same year, and the due date for the July 1 through December 31 reporting period is June 30 of the following year.

DISCUSSION

REPORTING PERIOD	DUE DATE
January 1 through June 30	December 31 of the same year
July 1 through December 31	June 30 of the following year

These regulations will be updated in accordance with California Health and Safety Code, subdivision (g) of Section 128735 as follows, in part:

"For patient discharges on or after January 1, 2000, through December 31, 2000, the reports shall be filed semiannually by each hospital or its designee not later than three months after the end of each semiannual period."

For the full text, refer to Appendix D, page 21 of this manual.

REPORTING PERIOD	DUE DATE
January 1 through June 30, 2000	September 30, 2000
July 1 through December 31, 2000	March 31, 2001

(b) Where there has been a change in the licensee of a hospital, the effective date of the change in licensee shall constitute the start of the reporting period for the new licensee, and this first reporting period shall end on June 30 or December 31, whichever occurs first. The final day of the reporting period for the previous licensee shall be the last day their licensure was effective, and the due date for the discharge data report shall be six months after the final day of this reporting period.

DISCUSSION

Example: If a hospital's licensee changes effective May 1, the first report for the new licensee will cover the period from May 1 through June 30, and will be due on December 31. The final report for the previous licensee will cover the period January 1 through April 30, and will be due October 31.

PREVIOUS LICENSEE		**NEW LICENSEE**	
REPORTING PERIOD	**DUE DATE**	**REPORTING PERIOD**	**DUE DATE**
January 1 through April 30	October 31	May 1 through June 30	December 31

(c) Discharge data reports shall be filed, as defined by Section 97005, by the date the discharge data report is due. Where a hospital has been granted an extension, pursuant to Section 97241, the ending date of the extension shall constitute the new due date for that discharge data report.

DISCUSSION

If the due date falls on a Saturday, Sunday, or State of California holiday, hospitals are allowed to have the data postmarked on the next State of California business day, without penalty.

Subsection (j) of Section 97005 reads:

(j) Disclosure reports, extension requests, appeal petitions, and other items are deemed to have been "filed" or "submitted" with the Office:

(1) as of the date they are postmarked by the United States Postal Service if properly addressed and postage prepaid;

(2) as of the date they are dated by a commercial carrier if properly addressed and delivery fee prepaid;

(3) when received by the Office via FAX machine or other electronic device;

(4) when received by the Office via hand delivery; or

(5) when otherwise received by the Office.

DEFINITIONS, AS USED IN THIS ARTICLE **Section 97212**

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code.

(b) Computer Media. Computer media means computer tape (reel or cartridge), diskette, or compact disk.

(c) Designated Agent. An entity designated by a hospital to submit that hospital's discharge data records to the Office's Discharge Data Program; may include the hospital's abstractor, a data processing firm, or the data processing unit in the hospital's corporate office.

(d) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one type of care to another type of care, as defined by Subsection (i) of Section 97212, or

(3) has died.

DISCUSSION

Inpatient: For a discharge to take place, the patient must have been formally admitted as an inpatient.

Babies born before admission to hospital (e.g., alternative birth center [ABC], your or another hospital's emergency room [ER], elevator), and who are admitted immediately to inpatient care, will be reported with the principal diagnosis of V30-V39 with a fourth digit of 1.

Mothers who deliver their babies in outpatient clinics (e.g., ABC) or your or another hospital's emergency room, and who then are admitted to inpatient care, will have a principal diagnosis reflecting the reason for admission, such as postpartum observation (V24) or postpartum complication (640-676) with fifth digit of 4.

See Subdivision (a) (4) of Section 1204 and Section 1204.3 of the Health and Safety Code for licensure of an ABC.

Death: When an inpatient expires, the death constitutes a discharge.

Organ Donor:

Outpatient: If a person expires in the emergency room and an organ is to be donated, no discharge data record will to be reported to OSHPD. The procedures for harvesting the organs from a outpatient donor will not be reported to OSHPD.

Inpatient: If an inpatient dies, the date of death is the date of discharge. Even if the organs are donated, the deceased patient is not to be retained with inpatient status or readmitted with a principal diagnosis of V59.x (organ donor). The procedures for harvesting the organs will not be reported to OSHPD.

Type of Care (TOC): If the patient is transferred within the hospital from one TOC to another as defined in Subsection (i) of this regulation, the patient must be considered discharged from the first TOC and admitted to the other TOC. Separate discharge data records will be reported for each stay.

Transfers Between Types of Care Within the Same Hospital:

One Record: Any patient transferred within acute care (e.g., from one of the following acute bed designations to another), is not a discharge and is reported to OSHPD as one record.

The following are examples of acute care:

Traditional medical/surgical care	Perinatal care
Intensive care	Pediatric Care
Coronary care	Oncology
Neonatal intensive care unit (NICU)	Acute respiratory care
Intensive care newborn nursery (ICNN)	Burn centers

Example: Transfer to ICNN/NICU. A newborn experiences respiratory distress and is transferred from the newborn nursery to ICNN/NICU in the same hospital. Only one discharge record will be reported. Normal newborn care and ICNN/NICU care are part of the acute TOC.

Multiple Records: Any patient transferred within the same hospital from one TOC to another will be discharged from the first TOC and a discharge data record will be reported for each TOC.

Example of three discharge data records for the same patient: A patient is admitted to acute care and transferred to psychiatric care (one record), then transferred from psychiatric care to chemical dependency recovery care (one record), and then transferred from chemical dependency recovery care to acute care (one record).

No Record:

Stillborn (Fetal Death): A discharge data record will not be reported to OSHPD.

Boarder Baby: Mother delivers baby; both mother and baby are discharged home. Mother develops complications and is readmitted. There is no other caretaker at home to care for baby. The baby goes back to hospital with the mother but is not admitted. The baby stays in the mother's room.

(e) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Healthcare Financing Administration.

(f) Do Not Resuscitate (DNR) Order. A DNR order is a directive from a physician in a patient's current inpatient medical record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following: cardiopulmonary resuscitation (CPR), intubation, defibrillation, cardioactive drugs, or assisted ventilation.

(g) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Healthcare Financing Administration, the National Center for Health Statistics, and the American Health Information Management Association).

(h) Method of Submission. A method of submission is the medium used by a hospital or its designated agent to submit a discharge data report to the Office and may be one of the following:

(1) computer tape (reel or cartridge),

(2) diskette,

(3) compact disk, or

(4) Manual Abstract Reporting Form (OSHPD 1370).

(i) Type of Care. Type of Care is defined as one of the following:

(1) Skilled Nursing/Intermediate Care. Skilled nursing/intermediate care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classifications of skilled nursing or intermediate care, as defined by Subdivisions (a)(2), (a)(3), or (a)(4), of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Physical rehabilitation care. Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds included on a hospital's license within the general acute care classification, as defined by Subdivision (a)(1) of Section 1250.1 of the Health and Safety Code, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 and of Section 70595.

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification of acute psychiatric beds, as defined by Subdivision (a)(5) of Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined by Subdivision (a) of Section 1250.2 of the Health and Safety Code.

(4) Chemical dependency recovery care. Chemical dependency recovery care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as chemical dependency recovery beds, as defined by Subdivision (a)(7) of Section 1250.1 and Subdivisions (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

DISCUSSION

This category includes chemical dependency recovery services provided as a supplemental service in existing general acute care beds and acute psychiatric beds in a general acute care hospital or in existing acute psychiatric beds in an acute psychiatric hospital or in existing beds in a freestanding facility (i.e., Subdivision (d) of Section 1250.3 of the Health and Safety Code).

(5) Acute care. Acute care, as defined by Subdivision (a)(1) of Section 1250.1 of the Health and Safety Code, means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital, other than those defined by Subsections (i)(1), (i)(2), (i)(3), and (i)(4) of this section.

DISCUSSION

The following are examples of acute care:

Traditional medical/surgical care	Perinatal care
Intensive care	Pediatric care
Coronary care	Oncology
Neonatal intensive care unit (NICU)	Acute respiratory care
Intensive care newborn nursery (ICNN)	Burn centers

(j) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined by Subdivision (c) of Section 128700 of the Health and Safety Code.

(k) Record. A record is defined as the set of data elements of the "hospital discharge abstract data record," as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for one patient.

(l) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period or for a shorter period, pursuant to Subsection (b) of Section 97211.

DISCUSSION

Types of Care are documented on the official license issued to the hospital by Licensing and Certification of the California State Department of Health Services. The hospital's license shows the number of beds in each classification and the number of general acute care beds in each designation.

REQUIRED REPORTING **Section 97213**

(a) Each hospital shall submit the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual reporting period, according to the format specified in Section 97215 and by the dates specified in Section 97211.

(b) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the acute care type of care, as defined by Subsection (i)(5) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "1" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "1" in the first position on each of these records.

(c) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care type of care, as defined by Subsection (i)(1) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "3" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "3" in the first position on each of these records.

(d) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the psychiatric care type of care, as defined by Subsection (i)(3) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "4" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "4" in the first position on each of these records.

(e) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the chemical dependency recovery care type of care, as defined by Subsection (i)(4) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "5" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "5" in the first position on each of these records.

(f) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the physical rehabilitation type of care, as defined by

Subsection (i)(2) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "6" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "6" in the first position on each of these records.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

1. TYPE OF CARE

1 Acute	5 Chem Dep	
3 SN/IC	6 Physical Rehab	
4 Psychiatric		

(g) Each discharge data report shall be submitted at one time, use one method of submission, and shall include all types of care.

(h) A hospital operating under a consolidated license may submit its discharge data report in separate sets of records that relate to separate physical plants.

DISCUSSION

A consolidated hospital may elect to submit separate discharge data reports for multiple sites using the existing separate Hospital Identification Numbers (HINs).

(i) If a hospital operating under a consolidated license submits its report in separate sets of records, the compilation of those sets must include all discharge records from all types of care and from all physical plants on that hospital's license. The complete compilation of sets of records for a hospital comprises that hospital's discharge data report for purposes of this Article.

FORM OF AUTHENTICATION **Section 97214**

(a) Hospitals submitting their hospital discharge abstract data records using the Manual Abstract Reporting Forms (OSHPD 1370) must submit with each discharge data report a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, as specified in Section 97239, the reporting period's beginning and ending dates, the number of records, and the following statement of certification, to be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ _____
(Name of hospital)

By: _____

Title: _____

Address: _____

A hospital that uses the Individual Hospital Transmittal Form (OSHPD 1370.1) is not required to submit a separate Discharge Data Certification Form (OSHPD 1370.3).

(b) Hospitals submitting their hospital discharge abstract data records using computer media must submit with each discharge data report a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, as specified in Section 97239, the reporting period's beginning and ending dates, the number of records, the tape specifications, and the signed statement of certification, as specified in Subsection (a) of Section 97214.

(c) Hospitals that designate an agent to submit their hospital discharge abstract data records must submit for each discharge data report a Discharge Data Certification Form (OSHPD 1370.3) to the Office's Discharge Data Program. This form shall be mailed after the end of each reporting period, and before that corresponding reporting period's due date. The certification must cover the same reporting period as the data submitted by the designated agent. This form, that contains the following statement of certification, shall be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the discharge abstract data records submitted to (name of my hospital's designated agent) for the period from (starting date) to (ending date) are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ _____
(Name of hospital)

By: _____

Title: _____

Address: _____

(d) Agents who have been designated by a hospital through the Discharge Data Certification Form (OSHPD 1370.3) to submit that hospital's discharge abstract data records must submit with each discharge data report a completed Agent's Transmittal Form (OSHPD 1370.2), including the following information clearly indicated: the hospital name, the hospital identification number, the reporting period's beginning and ending dates, the number of records, and the tape specifications. If the computer tape contains more than 13 reports, page two of the Agent's Transmittal Form (OSHPD 1370.2) shall be completed and attached to page one.

Designated agents are not required to submit any certification forms.

(e) Any hospital or designated agent may obtain free copies of the Individual Hospital Transmittal Form (OSHPD 1370.1), the Agent's Transmittal Form (OSHPD 1370.2), and the Discharge Data Certification Form (OSHPD 1370.3) by contacting the Office's Discharge Data Program.

FORMAT **Section 97215**

Patient discharge data shall be reported to the Office's Discharge Data Program on either the Manual Abstract Reporting Form (OSHPD 1370) or on computer media. The version of the Manual Abstract Reporting Form (OSHPD 1370) to be used depends on the date of discharge: discharges January 1, 1997, through December 31, 1998, shall use Form 1370 as revised June 1996, and discharges on or after January 1, 1999, shall use Form 1370 as revised in March 1998. The Office shall furnish each hospital using Form 1370 a copy of the appropriate version in advance of the start of each reporting period. Additional copies of Form 1370 shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

The format and specifications for the computer media depend on the date of discharge: discharges January 1, 1997, through December 31, 1998, shall comply with the Office's standard format and specifications as revised September 1, 1995, and discharges on or after January 1, 1999, shall comply with the Office's standard format and specifications as revised in March 1998. The Office shall furnish each hospital and designated agent a copy of the standard format and specifications before the start of the reporting period to which revisions apply. Additional copies may be obtained at no charge from the Office's Discharge Data Program.

Each hospital whose discharge data is submitted on computer media or, if the hospital has designated an agent, that agent, shall demonstrate its ability to comply with the standard format and specifications by submission of a test file of its data with which the Office can confirm compliance with the standard format and specifications.

The test file shall be submitted at least 60 days prior to the next reporting period due date by new hospitals or by existing hospitals after a change in any of the following: the Office's standard format and specifications; the hospital's or its designated agent's computer system, hardware or software; the computer media used by the hospital or its designated agent, the method of submission; or the designated agent, unless the new designated agent has already submitted a test file that complied with the standard format and specifications.

DISCUSSION

Standard Format and Specifications for Magnetic Tape, 3½ and 5¼" Diskette, or CD-ROM: See Appendix C.

Manual Abstract Reporting Form (OSHPD 1370): See Appendix F.

The Manual Abstract Reporting Form (OSHPD 1370) is available for download from the OSHPD web site: www.oshpd.state.ca.us

Confirmation of Test Data: Hospitals or their designated agents are required to submit test data

at least 60 days prior to the due date to allow sufficient time to confirm compliance with OSHPD's standard format and specifications.

A test of compliance with the standard format and specifications is required for the following circumstances:

- The standard format and specifications change.
- A new hospital opens and elects to submit its discharge data report using its own in-house computer system.
- A hospital changes its method of reporting (e.g., diskette to tape) and does not designate an agent to submit the report.
- A hospital/designated agent changes its computer system. While the same computer tape/diskette might continue to be used, the ability of the new system to produce discharge data in the standard format and specifications must be confirmed by OSHPD.

Test data may, or may not, be approved upon initial submission. Multiple submissions may be required to meet the standard format and specifications. Early submission of test data may be advantageous. Failure to have an approved format before the next reporting period's due date may result in the use of extension days and/or penalties being accrued due to late data submission.

ERRORS AND ACCEPTANCE

NOTE: The regulations are identified by bold and italics.

The section number located at the top right corner of the first page of each regulation refers to the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8.

ERROR TOLERANCE LEVELS **Section 97242**

(a) The error tolerance levels for discharge data items reported to the Office shall be as shown in Table 1. An error percentage that exceeds a specified error tolerance level shall be corrected by the hospital to the specified tolerance level.

(b) For error percentages for the data elements Admission Date and Discharge Date that do not exceed the error tolerance levels specified in Table 1, the Office shall delete each record with an error in one of these data elements from the hospital's report if the hospital fails to correct the data after a 30 calendar day notification by the Office of the errors.

(c) Effective with discharges occurring on or after July 1, 1990, for error percentages for data elements other than Admission Date and Discharge Date that do not exceed the error tolerance levels specified in Table 1, the Office shall assign default values of blank, which may be represented by a zero, except that for the data element Whether the Condition was Present at Admission for the Principal Diagnosis the Office shall assign the default value of Yes, if the hospital fails to correct the data after a 30 calendar day notification by the Office of the errors.

Table 1. Discharge Data Error Tolerance Levels

Data Element	*Error Tolerance Level*
Date of Birth	***.1%***
Sex	***.1%***
Race	***5%***
ZIP Code	***5%***
Patient Social Security Number	***.1%***
Admission Date	***.1%***
Source of Admission	***5%***
Type of Admission	***5%***
Discharge Date	***.1%***
Principal Diagnosis	***.1%***
Condition Present at Admission for Principal Diagnosis	***.1%***
Other Diagnoses	***.1%***
Condition Present at Admission for Other Diagnoses	***.1%***
External Cause of Injury	***.1%***
Principal Procedure	***.1%***
Principal Procedure Date	***1%***
Other Procedures	***.1%***
Other Procedures Dates	***1%***
Total Charges	***.1%***
Disposition of Patient	***1%***
Expected Source of Payment	***.1%***
Prehospital Care and Resuscitation	***.1%***

(d) (1) The error percentage for the data element Sex shall include unknown sex.

(2) The error percentage for the data element Race shall includ4e unknown race.

(3) The error percentage for the data element ZIP Code shall include partial and unknown type of admission.

(4) The error percentage for the data element Type of Admission shall include unknown type of admission.

(5) The error percentages for the data elements Principal Diagnosis and Other Diagnoses shall, for any one record, count all errors made in coding diagnoses as one error.

(6) The error percentages for the data elements Condition Present at Admission for Principal Diagnosis and Condition Present at Admission for Other Diagnoses shall, for any one record, count all errors made as one error.

(7) The error percentages for the data elements Principal Procedure and Other Procedures shall, for any one record, count all errors made in coding procedures as one error.

(8) The error percentages for the data elements Principal Procedure Date and Other Procedures Dates shall, for any one record, count all errors made as one error.

(9) The error percentage for the data element External Cause of Injury shall, for any one record, count all errors made in coding diagnoses as one error.

ACCEPTANCE CRITERIA **Section 97243**

(a) The discharge data report shall not be accepted but shall be rejected and returned to the hospital by the Office if the following requirements are not met:

(1) Submission of a completed transmittal form with the discharge data report, pursuant to Section 97214.

(2) Compliance with the Office's standard format and specifications, demonstrated by the hospital or its designated agent having previously submitted a set of data that the Office approved as being in conformance to the applicable standard format and specifications, pursuant to Section 97215.

(3) Submission of the appropriate version of the Manual Abstract Reporting Form (OSHPD 1370), as specified in Section 97215, when reporting other than on computer media.

(4) Submission by the hospital or by its designated agent in accordance with the most recent designation furnished by the hospital to the Office, pursuant to Section 97210.

(b) After a discharge data report is accepted, the hospital may be required to correct and/or replace the data if any of the following circumstances pertain:

(1) The Office is unable to read the computer media submitted.

(2) When the computer medium data file is read, it contains no data, contains data not covering the full reporting period, or contains a different number of records in the file than the number of records stated on the transmittal form.

(3) The data are not reported in compliance with Section 97215.

(4) The hospital identification number on each of the records being reported for the hospital does not agree with that hospital's identification number specified on the transmittal form, pursuant to Section 97214.

(5) Corrections are required as a result of not meeting the requirements of Section 97213; not meeting the data element definitions, as specified in Sections 97216 through 97233; and/or not meeting the error tolerance levels, as specified in Table 1 of Section 97242.

(6) All inpatient discharges, as defined by Subsection (d) of Section 97212, were not reported.

(c) If a hospital is required to replace or correct their discharge data, the Office shall allow a specified number of days for correction or replacement and shall establish a due date for re-submittal of the corrections or replacement. In determining the number of days to be allowed, the Office shall take account of the number and degree of errors and the number of extension days already granted, but in no case shall an aggregate total of more than 60 days for all extensions, corrections, replacements, and re-submittals be allowed.

DISCUSSION

A discharge data report is not acceptable in the following circumstances:

- OSHPD assesses that the report should be rejected because of visible problems.
- OSHPD has accepted the report and upon analysis determines that replacement or corrections are required. This type of determination cannot be made until OSHPD has once accepted and processed the data.
- Report is received from an entity other than the hospital's designated agent.

If any of the above conditions are present, the discharge data report may not be accepted and the hospital will be notified that its discharge data report is delinquent. The hospital will accrue $100 per day in penalties until the conditions for acceptance are met or an extension request is received and approved.

DEFINITIONS OF DATA ELEMENTS

NOTE: The regulations are identified by bold and italics.

The section number located at the top right corner of the first page of each regulation refers to the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8.

DISCHARGE DATA ELEMENTS

The 1999 discharge data set includes the following eighteen data elements (in alphabetical order):

Admission Date
Date of Birth
Discharge Date
Disposition of Patient
Expected Source of Payment
External Cause of Injury and Other E-Codes
Other Diagnoses and Whether the Conditions were Present at Admission
Other Procedures and Dates
Patient Social Security Number
Prehospital Care and Resuscitation (DNR – Do Not Resuscitate)
Principal Diagnosis and Whether the Condition was Present at Admission
Principal Procedure and Date
Race
Sex
Source of Admission
Total Charges
Type of Admission
ZIP Code

Additional Reporting Requirements

The hospital has the option to include the Abstract Record Number for use by OSHPD and the reporting hospital to identify specific records for correction. If submitted, the abstract record number is deleted prior to release of public data.

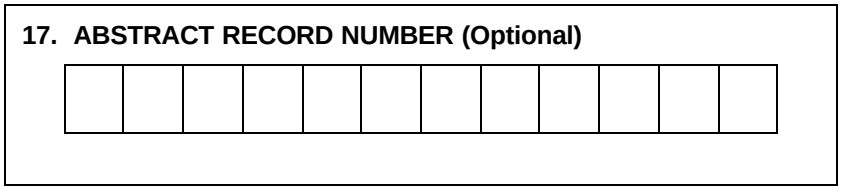
The Hospital Identification Number (HIN) is a required part of the discharge data record. Using the reported data elements, OSHPD computes and adds to the discharge data record the appropriate Diagnosis Related Group (DRG) and Major Diagnostic Category (MDC), using the current version of the Grouper approved by the Federal Healthcare Financing Administration (HCFA).

Type of Care is also a required part of the discharge record. Type of Care may be one of the following: Acute Care, Chemical Dependency Recovery Care, Psychiatric Care, Physical Rehabilitation Care, or Skilled Nursing/Intermediate Care.

ABSTRACT RECORD NUMBER (Optional)

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



In order to identify a particular patient's record from all others in the hospital, a unique code consisting of not more than 12 alphanumeric characters may be reported. The abstract record number is optional.

When the abstract record number is reported, it:

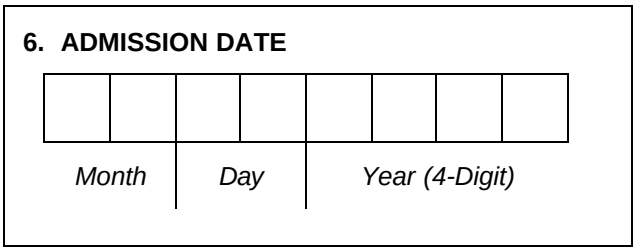
- May be used by OSHPD and reporting hospital to identify specific records for correction and outcome studies.
- Will be deleted prior to release of public data.
- May be the medical record number.
- May include hyphens or slashes. Other special characters (e.g., period, comma, apostrophe) must not be included.
- Should be reported from the left-most position of the field. Do not fill blank spaces with zeroes.

ADMISSION DATE — Section 97221

The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined by Subsection (i) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this record.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Critical Data Element: If the reported admission date is blank or invalid (such as June 31) and is not corrected by the hospital after it is identified by OSHPD as an error, the entire discharge data record will be deleted.

Four Digit Year: Hospital medical record systems are expected to be Year 2000 (Y2K) compliant for discharges on or after January 1, 1999. A compliant system should ensure the proper recording of the 4-digit year in the medical record system and eliminate any ambiguity of the correct century. If a hospital's medical record system is not Y2K compliant, processes should be in place to ensure the continued correct reporting of the 4-digit year when the admission date century is 20xx.

Reporting Requirements:

- The actual date of admission to inpatient care and the actual date of discharge must be reported, even if the length of stay is over 365 days.
- If the patient is admitted to inpatient care on May 3, 1999, the reported value is 05031999.

Discharge/Transfer: Make certain that the date recorded represents the initial date of admission to the hospital for that episode of inpatient care. A separate episode of inpatient care (a discharge) is to be reported when a patient is transferred between hospitals or within a hospital between Types of Care. The admission date for the initial episode is when the patient is first admitted to the hospital for inpatient care, regardless of TOC. If the patient is transferred from one TOC to another (e.g., from acute care to skilled nursing/intermediate care), the admission date for the second episode would be the date the patient was transferred to skilled nursing/intermediate care.

One Day Stays (Same Day): One day stays include patients admitted and discharged on the same day. Such patients are formally admitted (expected to remain overnight or longer) but are discharged on the day of admission. A discharge data record must be reported to OSHPD.

Observation Patients: When an observation patient is admitted to inpatient care, the admission date to be reported is the date the patient is admitted to inpatient care. See Glossary of Terms and Abbreviations (Appendix A) for definition of observation.

Ambulatory Surgery Facility and Hospital Outpatient Services: Patients are sometimes admitted within 48 hours of procedures performed in a licensed ambulatory surgery facility or as an outpatient at a hospital. Under certain circumstances, the procedure may be reported on the discharge data record. If so, the procedure date must be reported when it actually occurred and not be changed to the admission date. OSHPD accommodates procedure dates three days prior to the admission date.

Emergency Room: Patients are often seen in the emergency room on one day and remain until the next day and are then admitted to inpatient care. The admission date reported is the date the patient actually is admitted to inpatient care.

Skilled Nursing Bed Hold Days: Skilled nursing **bed hold days are not reported** to OSHPD. A patient cannot be in two Types of Care at the same time.

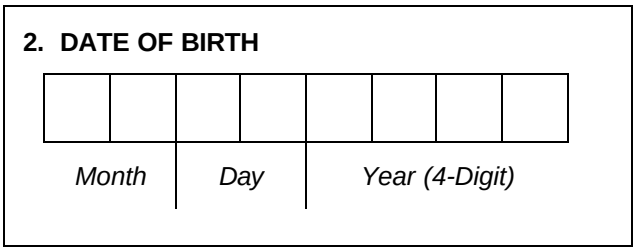
Length of Stay: Days calculated by subtracting the date of admission from the date of discharge. This is important in studying hospital utilization and conducting hospital outcomes studies.

DATE OF BIRTH — Section 97216

The patient's birth date shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year of birth. The numeric form for days and months from 1 to 9 must have a zero as the first digit. When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth shall be reported. If only the age is known, the estimated year of birth shall be reported. If the month and year of birth are known, and the exact day is not, the year, the month, and zeros for the day shall be reported.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Critical Data Element: If the reported date of birth is blank or invalid (such as June 31) and is not corrected by the hospital after it is identified by OSHPD as an error, the entire discharge data record will be deleted.

Four Digit Year: Hospital medical record systems are expected to be Year 2000 (Y2K) compliant for discharges on or after January 1, 1999.

Partial Dates of Birth:

Please provide as much data as is available.

If the patient's month and day of birth are unknown, and the year is known, the month will be 00, the day will be 00, and the given year.

Example: The patient was born in 1948. Report the date of birth as 00001948.

If the patient's month, day, and year of birth are unknown, and the patient's age is known, the patient's age at the time of admission will be subtracted from the year of admission to determine the year of birth.

Example: The patient is known to be 65 years old and the year of admission is 1997 (1997 - 65 = 1932). The date of birth will be 00001932.

If the patient's day of birth is unknown, and the month and year are known, the day will be 00.

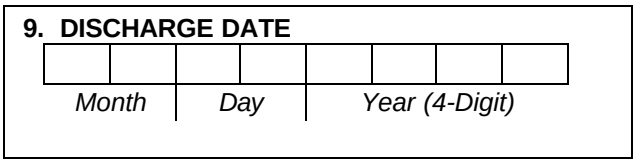
Example: The patient was born in November 1952. The date of birth will be 11001952.

DISCHARGE DATE — Section 97224

The patient's date of discharge shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Critical Data Element: If the reported discharge date is blank, outside the report period, or invalid (such as June 31) and is not corrected by the hospital after it is identified by OSHPD as an error, the entire discharge data record will be deleted.

Four Digit Year: Hospital medical record systems are expected to be Year 2000 (Y2K) compliant for discharges on or after January 1, 1999

Reporting Requirements:

- The actual date of discharge from inpatient care (or transfer to another TOC) must be reported, even if the length of stay is over 365 days.
- If the patient is discharged on February 5, 2000, the reported value is 02052000.

Discharge/Transfer: A separate episode of inpatient care (a discharge) is to be reported when a patient is transferred between hospitals or within a hospital between Types of Care. If the patient is transferred from one TOC to another (e.g., from acute care to skilled nursing/intermediate care), the discharge date for the acute care discharge data record would be the date the patient was transferred to skilled nursing/intermediate care.

One Day Stays (Same Day): One day stays include patients admitted and discharged on the same day. Such patients are formally admitted (expected to remain overnight or longer) but are discharged on the day of admission. A discharge data record must be reported to OSHPD.
Skilled Nursing Bed Hold Days: Skilled nursing **bed hold days are not reported** to OSHPD. A patient cannot be in two levels of care at the same time.

DISPOSITION OF PATIENT — Section 97231

Effective with discharges on or after January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the reporting facility, shall be reported as one of the following:

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

14. **DISPOSITION OF PATIENT**		
01 Routine (Home)	07 SN/IC	
Within This Hospital	08 Residential Care Facility	
02 Acute Care	09 Prison Jail	
03 Other Care	10 Against Medical Advice	
04 SN/IC	11 Died	
To Another Hospital	12 Home Health Service	
05 Acute Care	13 Other	
06 Other Care (Not SN/IC)		

(a) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office or a clinic shall be included. Excludes patients referred to a home health service.

DISCUSSION

This category includes patients discharged to a home environment (e.g., half-way house, group home, community care facility, foster care, woman's shelter). This category includes patients who go home either directly from the hospital, or after being treated at a licensed ambulatory surgery facility, or after receiving outpatient services at your or another hospital. This category also includes patients who are homeless; it is used to indicate discharge to a location not licensed as a hospital by the Department of Health Services.

(b) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit within this reporting hospital.

DISCUSSION

See Examples 1, 2, and 3, at the end of this subsection.

Consolidated Hospital Submitting One Discharge Data Report:

Includes patients discharged from a TOC 3, 4, 5, or 6 bed to a TOC 1 bed.

(c) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit within this reporting hospital.

DISCUSSION

Consolidated Hospital Submitting One Discharge Data Report:

Includes patients discharged from a:

- TOC 1 bed to a TOC 4, 5, or 6 bed.
- TOC 3 bed to a TOC 4, 5, or 6 bed.
- TOC 4 bed to a TOC 5 or 6 bed.
- TOC 5 bed to a TOC 4 or 6 bed.
- TOC 6 bed to a TOC 4 or 5 bed.

DISCUSSION

(d) Skilled Nursing/Intermediate Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

Consolidated Hospital Submitting One Discharge Data Report:

Includes patients discharged from a:

- TOC 1 bed to a TOC 3 bed.
- TOC 4 bed to a TOC 3 bed.
- TOC 5 bed to a TOC 3 bed.
- TOC 6 bed to a TOC 3 bed.

This category includes patients discharged to:

- A skilled nursing bed for the Medi-Cal Subacute Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- A skilled nursing bed for the Medi-Cal Transitional Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An acute care bed that is used to provide skilled nursing care in an approved swing bed program.
- An Institution for Mental Disease (IMD). See Glossary of Terms and Abbreviations (Appendix A) for definition.

DISCUSSION

(e) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of another hospital.

See Example 4, at the end of this subsection.

This category includes patients discharged:

- Between a consolidated hospital that has elected to submit two or more discharge data reports to OSHPD.
- To an acute care bed at an out of state, federal, or foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.
- To an acute care bed for the Medi-Cal Subacute Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- To an acute care bed for the Medi-Cal Transitional Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.

(f) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

DISCUSSION

This category includes patients discharged:

- Between a consolidated hospital that has elected to submit two discharge data reports to OSHPD.
- To an acute care bed at an out of state, federal, or foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.

(g) Skilled Nursing/Intermediate Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within another hospital, or to a Congregate Living Health Facility, as defined by Subsection (i) of Section 1250 of the Health and Safety Code.

DISCUSSION

This category includes patients discharged:

- Between a consolidated hospital that has elected to submit two or more discharge data reports to OSHPD.
- To a skilled nursing bed at an out of state, federal, or foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.
- To a skilled nursing bed for the Medi-Cal Subacute Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- To a skilled nursing bed for the Medi-Cal Transitional Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- To an acute care bed that is being used to provide skilled nursing care in an approved swing bed program.
- To an IMD. See Glossary of Terms and Abbreviations (Appendix A) for definition.

(h) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

DISCUSSION

This category includes patients discharged to:

- Various types of facilities that provide supportive and custodial care. The facilities are licensed by the California Department of Social Services and are not considered to be health facilities. The facilities are referred to by a variety of terms (e.g., board and care, residential care facilities for the elderly).
- Mental Health Rehabilitation Centers (MHRC). See Glossary of Terms and Abbreviations (Appendix A) for definition.

(i) Prison/Jail. A patient discharged to a correctional institution.

DISCUSSION

This category includes patients discharged to juvenile hall.

(j) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from away without leave (AWOL) status are included in this category.

(k) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(l) Home Health Service. A patient referred to a licensed home health service program.

(m) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a freestanding, not hospital-based, inpatient hospice facility.

ADDITIONAL DISCUSSION FOR ALL CATEGORIES

Skilled Nursing Bed Hold Days: Skilled nursing **bed hold days are not reported** to OSHPD. A patient cannot be reported in two Types of Care at the same time.

Mode of Transportation: The mode of transporting a patient from one health facility to another is irrelevant to the patient's disposition.

EXAMPLES OF DISPOSITION OF PATIENT, ACUTE CARE, WITHIN THIS HOSPITAL

EXAMPLE 1

1. Lucy is discharged from skilled nursing care at your hospital to acute care at your hospital.

Q. How is Lucy's Disposition reported on the skilled nursing record?

A. Lucy was discharged to "Acute Care, Within Your Hospital" which would be "02", which is reported as shown below.

14. DISPOSITION OF PATIENT		
01 Routine (Home)	07 SN/IC	
Within This Hospital	08 Residential Care Facility	
02 Acute Care	09 Prison Jail	
03 Other Care	10 Against Medical Advice	
04 SN/IC	11 Died	
To Another Hospital	12 Home Health Service	
05 Acute Care	13 Other	0 2
06 Other Care (Not SN/IC)		

EXAMPLES OF DISPOSITION OF PATIENT, ACUTE CARE, WITHIN THIS HOSPITAL

EXAMPLE 2

For a **CONSOLIDATED HOSPITAL** that submits discharge data on **ONE REPORT** with one Hospital Identification Number:

2. Alberto is discharged from skilled nursing care at your hospital to acute care at your hospital.

Q. How is Alberto's disposition reported on the skilled nursing record?

A. Alberto was discharged to "Acute Care, Within Your Hospital" *because your data is submitted on one report*; this should be reported by using "02" as shown below

14. DISPOSITION OF PATIENT		
01 Routine (Home)	07 SN/IC	
Within This Hospital	08 Residential Care Facility	
02 Acute Care	09 Prison Jail	
03 Other Care	10 Against Medical Advice	
04 SN/IC	11 Died	
To Another Hospital	12 Home Health Service	
05 Acute Care	13 Other	0 2
06 Other Care (Not SN/IC)		

EXAMPLES OF DISPOSITION OF PATIENT, ACUTE CARE, WITHIN THIS HOSPITAL

EXAMPLE 3

3. Riley is discharged from psychiatric care at your hospital to acute care at your hospital.

Q. What is the Disposition of the Patient on the psychiatric care record?

A. The patient was discharged to "Acute Care" within your hospital; this should be reported by using "02" as shown below.

14. DISPOSITION OF PATIENT		
01 Routine (Home)	07 SN/IC	
Within This Hospital	08 Residential Care Facility	
02 Acute Care	09 Prison Jail	
03 Other Care	10 Against Medical Advice	
04 SN/IC	11 Died	
To Another Hospital	12 Home Health Service	
05 Acute Care	13 Other	0 2
06 Other Care (Not SN/IC)		

EXAMPLES OF DISPOSITION OF PATIENT, ACUTE CARE, WITHIN THIS HOSPITAL

EXAMPLE 4

For a **CONSOLIDATED HOSPITAL** that submits discharge data on **TWO OR MORE REPORTS** with separate HINs:

4. A patient is discharged from skilled nursing care at one of your hospital's consolidated sites to acute care at another of your consolidated sites.

Q. What is the Disposition Of Patient of the skilled nursing record? (*Hint: Where was the patient discharged to?*)

A. The patient was discharged to "To Another Hospital, Acute Care" *because your data is submitted on two or more reports*); this should be reported by using "05" as shown below.

14. DISPOSITION OF PATIENT		
01 Routine (Home)	07 SN/IC	
Within This Hospital	08 Residential Care Facility	
02 Acute Care	09 Prison Jail	
03 Other Care	10 Against Medical Advice	
04 SN/IC	11 Died	
To Another Hospital	12 Home Health Service	
05 Acute Care	13 Other	0 5
06 Other Care (Not SN/IC)		

EXAMPLES OF DISPOSITION OF PATIENT, SKILLED NURSING / INTERMEDIATE CARE WITHIN THIS HOSPITAL

EXAMPLE 5

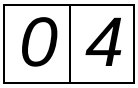
5. Jenna is discharged from acute care at your hospital to skilled nursing care at your hospital.

Q. What is the Disposition of the Patient for the acute care record?

A. Jenna was discharged to "To SN/IC, Within This Hospital"; this should be reported by using "04" as shown below.

14. DISPOSITION OF PATIENT

01 Routine (Home)	07 SN/IC
Within This Hospital	08 Residential Care Facility
02 Acute Care	09 Prison Jail
03 Other Care	10 Against Medical Advice
04 SN/IC	11 Died
To Another Hospital	12 Home Health Service
05 Acute Care	13 Other
06 Other Care (Not SN/IC)	



EXPECTED SOURCE OF PAYMENT — Section 97232

(a) Effective with discharges on or after January 1, 1999, the patient's expected source of payment shall be reported using the following:

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

16. EXPECTED SOURCE OF PAYMENT

PAYER CATEGORY			TYPE OF COVERAGE		NAME OF PLAN
01 Medicare	06 Other Government		1 Managed Care - Knox – Keene/ MCOHS		
02 Medi-Cal	07 Other Indigent				
03 Private Coverage	08 Self Pay				
04 Workers' Compensation	09 Other Payer		2 Managed Care - Other		
05 County Indigent Programs			3 Traditional Coverage		(0001-9999 Plan Code Name)

Valid combinations for reporting Expected Source of Payment

FOR PAYER CATEGORY	SELECT TYPE OF COVERAGE	NAME OF KNOX-KEENE (HMO) PLAN OR MCOHS PLAN
01, 02, 03, 04, 05, 06	1 Knox-Keene (HMO) or MCOHS Plan	Report valid plan code number (Refer to Table 1 and Table 2)
01, 02, 03, 04, 05, 06	2 Managed Care – Other (PPO, IPO, POS, etc.)	0000
01, 02, 03, 04, 05, 06	3 Traditional Coverage (Fee for Service)	0000
07, 08, 09	0 No Coverage	0000

(1) Payer Category: The type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill.

This data element is defined as the source of payment that is expected, at the time of admission, to pay or did pay the greatest share of the patient's bill. Hospitals may report to OSHPD the most recent source of payment for patients with stays exceeding a year.

(A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health Systems. Knox-Keene Plans are Health Maintenance Organizations (HMO) Plans licensed by the Department of Corporations under the Knox-Keene Healthcare Service Plan Act of 1975. Plans and Plan Code Numbers are listed in Table 1. Also include in this managed care Type of Coverage category are the Medi-Cal County Organized Health Systems (MCOHS) listed in Table 2.
- Managed Care – Other. This Type of Coverage should be reported for all non-HMO managed care. Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), and Exclusive Provider Organization with Point-of-Service option (POS) are examples of Managed Care – Other.
- Traditional Coverage. All other forms of healthcare coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for service payers.

(B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(A) Medicare*** above.

(C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, or Shriners.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(A) Medicare.***

Automobile Insurance payments are included in this Payer Category.

(D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(A) Medicare.***

(E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(A) Medicare.***

(F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections (b)(1)(A), (b)(1)(B), (b)(1)(D), or (b)(1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

DISCUSSION

Select one of the following Type of Coverage categories when reporting this category as the payer:

- Managed Care – Knox-Keene/Medi-Cal County Organized Health System
- Managed Care – Other
- Traditional Coverage

For a more detailed description of the Types of Coverage categories, refer to the discussion section for ***(A) Medicare.***

(G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (b)(1)(E) of this section.

DISCUSSION

This category is excluded from reporting Type of Coverage and Name of Plan. The Other Indigent record will have no Type of Coverage or Name of Plan to render payment. Use of Plan Code Number 8000, "Other", is inappropriate because the Other Indigent patient does not have Knox-Keene (HMO) coverage. Unused numeric fields may be zero-filled.

(H) Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan.

DISCUSSION

This category is excluded from reporting Type of Coverage and Name of Plan. The Self-Pay record will have no Type of Coverage or Name of Plan to render payment. Use of Plan Code Number 8000, "Other", is inappropriate because the Self-Pay patient does not have Knox-Keene (HMO) coverage. Unused numeric fields may be zero-filled.

(I) Other Payer. Any third party payment not included in Subsections (b)(1)(A) through (b)(1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

DISCUSSION:

This category is excluded from reporting Type of Coverage and Name of Plan. No payment will be required of patients reported as Other Payer. The record will have no Type of Coverage or Name of Plan to render payment. Use of Plan Code Number 8000, "Other", is inappropriate because the Other Payer patient does not have Knox-Keene (HMO) coverage. Unused numeric fields may be zero-filled.

Live organ donors are included in this payer category.

(2) Type of Coverage. For each Payer Category, Subsections (b)(1)(A) through (b)(1)(F) of this section, select one of the following Types of Coverage:

DISCUSSION

A Type of Coverage category must be selected when reporting the following Payer Categories:

- Medicare
- Medi-Cal
- Private Coverage
- Workers' Compensation
- County Indigent Programs
- Other Government

(A) Managed Care - Knox-Keene/Medi-Cal County Organized Health System. Healthcare service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Corporations under the Knox-Keene Healthcare Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems.

(B) Managed Care - Other. Healthcare plans, except those in Subsection (b)(2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Exclusive Provider Organization with Point-of-Service option (POS).

(C) Traditional Coverage. All other forms of healthcare coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

(3) Name of Plan. (A) For discharges occurring on or after January 1, 1999, up to and including discharges occurring on December 31, 1999, report the names of those plans which are licensed under the Knox-Keene Healthcare Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (b)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan as shown in Table 1 or the Medi-Cal County Organized Health System as shown in Table 2.

DISCUSSION

A Name of Plan/Code Number from either Table 1 or Table 2 must be selected when reporting the Managed Care – Knox-Keene (HMO)/Medi-Cal County Organized Health System (MCOHS) category of Type of Coverage. Separate Tables exist for 1999 and 2000 discharges.

Plan Code Number ***8000*** may be used *only* to report Knox-Keene Licensed Plans that are not listed because they obtained licensure after the table was created. Questions regarding appropriate Plan Code Numbers for unlisted Plans may be referred to your Patient Discharge Data Analyst. ***8000*** should not be used to report PPO, EPO or other non-HMO coverage.

If no Knox-Keene (HMO) or MCOHS Plan is to be reported the unused numeric fields may be zero-filled or they may be left unfilled.

Please report **only** California HMO's under Type of Coverage Managed Care Knox-Keene/MCOHS (1). Inpatient care covered by an out of state/non-California HMO is reported as Managed Care-Other (2).

Table 1. and Table 2. below are for use with discharges occurring on, or after, January 1, 1999, up to and including, discharges occurring on December 31, 1999.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers: For use with discharges occurring in 1999.

Plan Code Names	*Plan Code Numbers*
Aetna Health Plans of California, Inc.	*0176*
Alameda Alliance for Health	*0328*
American Family Care	*0322*
Blue Cross of California	*0303*
Blue Shield of California	*0043*
BPS HMO	*0314*
Brown and Toland Medical Group	*0352*
Calaveras Provider Network	*0365*
Care 1st Health Plan	*0326*
Careamerica-Southern California, Inc.	*0234*
Chinese Community Health Plan	*0278*
Cigna Healthcare of California, Inc.	*0152*
Community Health Group	*0200*
Community Health Plan (County of Los Angeles)	*0248*
Concentrated Care, Inc.	*0360*
Contra Costa Health Plan	*0054*
FPA Medical Management of California, Inc	*0350*
Great American Health Plan	*0327*
Greater Pacific HMO Inc	*0317*
HAI	*0292*
Healthmax America	*0277*
Health Net	*0300*
Health Plan of America (HPA)	*0126*
Health Plan of the Redwoods	*0159*
Heritage Provider Network, Inc.	*0357*
Inland Empire Health Plan	*0346*
Inter Valley Health Plan	*0151*
Kaiser Foundation Added Choice Health Plan	*0289*
Kaiser Foundation Health Plan, Inc.	*0055*
Kern Health Systems Inc	*0335*
Key Health Plan of California	*0343*
Lifeguard, Inc.	*0142*
LA Care Health Plan	*0355*
Managed Health Network	*0196*
Maxicare	*0002*
MCC Behavioral Care of California, Inc.	*0298*
MedPartners Provider Network, Inc.	*0345*
Metrahealthcare Plan	*0266*

Merit Behavioral Care of California, Inc.	***0288***
Monarch Plan Inc.	***0270***
National Health Plans	***0222***
National HMO	***0222***
Occupational Health Services (OHS)	***0235***
Omni Healthcare, Inc.	***0238***
One Health Plan of California Inc.	***0325***
Pacificare Behavioral Health of California Inc.	***0301***
Pacificare of California	***0126***
Priorityplus of California	***0237***
Prucare Plus	***0296***
Qualmed Plans for Health	***0300***
Regents of the University of California	***0354***
San Francisco Health Plan	***0349***
Santa Clara County Family Health Plan	***0351***
Secure Horizons	***0126***
Sharp Health Plan	***0310***
Smartcare Health Plan	***0212***
The Health Plan of San Joaquin	***0338***
Tower Health Service	***0324***
UHC Healthcare	***0266***
UHP Healthcare	***0008***
Universal Care	***0209***
Valley Health Plan	***0236***
Value Behavioral Health of California, Inc.	***0293***
Ventura County Healthcare Plan	***0344***
Vista Behavioral Health Plan	***0102***
Western Health Advantage	***0348***
Other HMO	***8000***

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers: For Use with Discharges occurring in 1999

Name of Medi-Cal County Organized Health System	*Plan Code Numbers*
Cal Optima (Orange County)	***9030***
Health Plan of San Mateo (San Mateo County)	***9041***
Santa Barbara Health Authority (Santa Barbara County)	***9042***
Santa Cruz County Health Options (Santa Cruz County)	***9044***
Solano Partnership Health Plan (Solano County)	***9048***

(B) For discharges occurring on or after January 1, 2000, report the names of those plans which are licensed under the Knox-Keene Healthcare Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a) (2) (A) of this section, report the plan code number representing the name of the Knox Keene licensed plan as shown in Table 1, or the Medical County Organized Health System as shown in Table 2.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers: For use with discharges occurring in 2000

Plan Code Names	*Plan Code Numbers*
Aetna Health Plans of California, Inc.	*0176*
Alameda Alliance for Health	*0328*
Blue Cross of California	*0303*
Blue Shield of California	*0043*
BPS HMO	*0314*
Calaveras Provider Network	*0365*
Care 1st Health Plan	*0326*
Cedars-Sinai Provider Plan, LLC	*0366*
Chinese Community Health Plan	*0278*
Cigna Healthcare of California, Inc.	*0152*
Community Health Group	*0200*
Community Health Plan (County of Los Angeles)	*0248*
Concentrated Care, Inc.	*0360*
Contra Costa Health Plan	*0054*
FPA Medical Management of California, Inc	*0350*
Great American Health Plan	*0327*
Greater Pacific HMO Inc	*0317*
HAI, Hai-Ca	*0292*
Healthmax America	*0277*
Health Net	*0300*
Health Plan of America (HPA)	*0126*
Health Plan of the Redwoods	*0159*
Health Plan of San Mateo Healthy Families, not COHS	*0358*
Heritage Provider Network, Inc.	*0357*
Holman Professional Counseling Centers	*0231*
Inland Empire Health Plan	*0346*
Inter Valley Health Plan	*0151*
Kaiser Foundation Added Choice Health Plan	*0289*
Kaiser Foundation Health Plan, Inc.	*0055*

Kern Health Systems Inc	***0335***
Key Health Plan of California	***0343***
Key HMO Key Choice	***0343***
Lifeguard, Inc.	***0142***
LA Care Health Plan	***0355***
Managed Health Network	***0196***
Maxicare	***0002***
MCC Behavioral Care of California, Inc.	***0298***
MedPartners Provider Network, Inc.	***0345***
Metrahealthcare Plan	***0266***
Merit Behavioral Care of California, Inc.	***0288***
Molina	***0322***
National Health Plans	***0222***
National HMO	***0222***
Omni Healthcare, Inc.	***0238***
One Health Plan of California Inc.	***0325***
On Lok Senior Health Services	***0385***
Pacificare Behavioral Health of California Inc.	***0301***
Pacificare of California	***0126***
Primecare Medical Network, Inc. A CA. Corp.	***0367***
Priorityplus of California	***0237***
Prucare Plus	***0296***
Qualmed Plans for Health/Bridgeway	***0300***
Regents of the University of California	***0354***
San Francisco Health Plan	***0349***
Santa Clara Family Health Plan	***0351***
Scripps Clinic Health Plan Services, Inc.	***0377***
Secure Horizons	***0126***
Sharp Health Plan	***0310***
Simnsa Healthcare	***0393***
Sistemas Medicos Nacionales, S.A. De C.V.	***0393***
Smartcare Health Plan	***0212***
The Health Plan of San Joaquin	***0338***
Thipa Management Consultants, Incorporated	***0363***
Tower Health Service	***0324***
UHC Healthcare	***0266***
UHP Healthcare	***0008***
Universal Care	***0209***
Valley Health Plan	***0236***
Value Behavioral Health & American Psychol.	***0293***
Ventura County Healthcare Plan	***0344***
Vista Behavioral Health Plan	***0102***

Western Health Advantage	***0348***
Other HMO	***8000***

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers: For use with discharges occurring in 2000

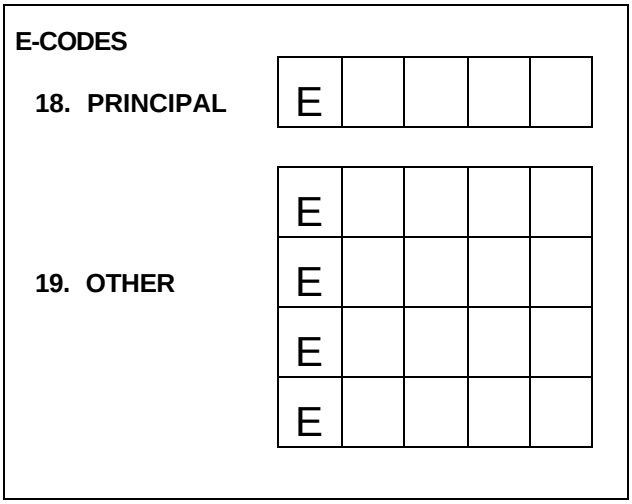
Name of Medi-Cal County Organized Health System	*Plan Code Numbers*
Cal Optima (Orange County)	***9030***
Health Plan of San Mateo (San Mateo County)	***9041***
Santa Barbara Health Authority (Santa Barbara County)	***9042***
Central Coast Alliance For Health (Santa Cruz County)	***9044***
Solano Partnership Health Plan (Solano County)	***9048***

EXTERNAL CAUSE OF INJURY — Section 97227

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported only for the first inpatient hospitalization during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect first diagnosed and/or treated during the current inpatient hospitalization.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Reporting Requirements:

- If the external cause of injury, poisoning, or adverse effect was reported on a first inpatient discharge data record to OSHPD, it should not be reported again for the same patient.
- If the external cause of injury, poisoning, or adverse effect was previously treated only on an outpatient basis (e.g., emergency room, ambulance, outpatient clinic, physician's office), the external cause of injury, poisoning, or adverse effect must be reported during the first inpatient hospitalization for the injury, poisoning, or adverse effect.
- Reporting medical/surgical misadventure and abnormal reaction codes (categories E870-E879) is optional.
- Identical E-codes will not be accepted on the same inpatient discharge data record. This is consistent with the guidelines for E-codes in *Coding Clinic for ICD-9-CM*.
- If more than one drug or substance caused a poisoning or adverse effect, report all E-codes necessary to describe all substances.
- Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) must never be reported in the Other Diagnoses code fields. Such codes must only be reported in the External Cause of Injury code fields.

Principal E-code: The principal E-code is defined as the external cause of injury or poisoning which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect initially diagnosed and/or treated during the current inpatient admission. If sequencing the external cause of the most severe injury as the principal E-code is contradictory to the guidelines given in ICD-9-CM, OSHPD reporting requirements take precedence.

Other E-codes:

- Defined as additional ICD-9-CM codes from the range E800-E999 necessary to completely describe the mechanisms of injuries, poisonings, or adverse effects diagnosed and/or treated during the first inpatient admission.
- Include category E849 (place of occurrence) if documented in the medical record and not previously reported to OSHPD on a first inpatient admission.

Place of occurrence codes (category E849) are:

- Invalid as the principal E-code.
- Reported to OSHPD if the principal E-code does not specify the place of occurrence.
- Reported to OSHPD as unspecified (E849.9) when the place of occurrence is not specified in the medical record.

Number of Other E-codes: Four other E-codes in addition to the principal E-code may be reported to OSHPD.

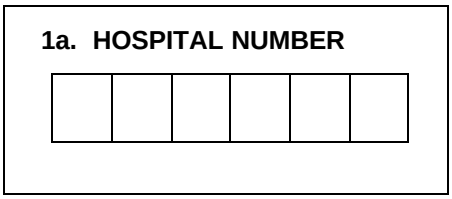
- If the reporting format limits the number of E-codes that can be used in reporting to OSHPD, refer to the Coding Clinic for ICD-9-CM for coding multiple E-codes in the same three-digit categories or different three-digit categories. In either case, include the place of occurrence E-code.

HOSPITAL IDENTIFICATION NUMBER (HIN) Section 97239

Effective with discharges on or after January 1, 1995, the last six digits of the 9-digit identification number assigned by the Office shall be reported as part of each patient record, either in the specified section of the Manual Abstract Reporting Form (OSHPD 1370) or in positions 2 through 7 on computer media format.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



OSHPD will accept only a six-digit HIN. The first two digits indicate the hospital's county location, and the last four digits are unique to the hospital and are assigned by OSHPD. The same six-digit HIN must be reported on the transmittal form and on computer media format in positions 2 through 7 of each discharge data record.

OTHER DIAGNOSES AND WHETHER THE CONDITIONS WERE PRESENT AT ADMISSION

Section 97226

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the supplementary classification of external causes of injury and poisoning (E800-E999) shall not be reported as other diagnoses.

(b) Effective with discharges on or after January 1, 1996, whether the patient's other diagnoses were present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

10. PRINCIPAL DIAGNOSIS CODE					10a. PRESENT AT ADMISSION
					Y = Yes N = No U = Uncertain
11. OTHER DIAGNOSES					**11a. PRESENT AT ADMISSION**
a.					
b.					
c.					
d.					

Other Diagnoses:

Reporting Requirement: Identical diagnosis codes must not be reported on the same inpatient discharge data record.

Number of Other Diagnoses: Up to twenty-four other diagnoses may be reported to OSHPD. Discharge data becomes increasingly useful and valuable for research when all diagnoses that indicate risk factors are reported. Please report all relevant diagnoses.

Other Coding Systems:

- Morphology Codes are not accepted by OSHPD.
- SNODO codes are not accepted by OSHPD.
- DSM-IV codes are not accepted by OSHPD.

ICD-9-CM Codes:

Conditions should be coded that affect patient care in terms of requiring:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care and/or monitoring

Refer to the official guidelines for coding and reporting the other diagnoses in *Coding Clinic for ICD-9-CM.*

Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) will never be reported in the other diagnosis code fields. Such codes must only be reported in the External Causes of Injury code fields.

Condition Present at Admission for Other Diagnoses:

Purpose:

The purpose of collecting the data element Condition Present at Admission is to differentiate between conditions present at admission and conditions that developed during an inpatient admission. The focus is to assess the timing of when the condition was present.

Reporting Requirements:

- Each principal diagnosis and all other diagnoses must have an indicator for reporting whether or not a condition is present at admission by choosing one of the following responses:

  Yes

  No

  Uncertain

- The ICD-9-CM E-codes, External Causes of Injury and Poisoning, are excluded from this reporting requirement.

Parameters for Reporting:

If the physician states that a condition is present (Y) or not present (N) at admission or is uncertain (U) whether or not the condition was present at admission, the physician's statement takes precedence over the following parameters.

A condition is considered present at admission if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes).

When a condition is present prior to or at the time of the current inpatient admission, the indicator is reported yes (Y).

When a condition develops during the current inpatient admission and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No (N).

When it is not clearly indicated that a condition is present at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain (U).

Coding professionals will need to use their best judgment to determine whether or not a condition is present at the time of the current inpatient admission. If there is doubt as to whether or not the condition is present at admission, coding professionals are encouraged to ask the physician.

Indicators for Acute and Chronic Conditions:

Chronic conditions that may not have been identified prior to or at the time of the current inpatient admission would be considered to have been present at admission. The indicator for the chronic condition is reported Yes.

Example: Lung cancer discovered during admission 162.9 Y

When there are separate ICD-9-CM codes for some conditions that are described as both acute and chronic, the indicators are reported separately as follows:

If acute and chronic conditions are both present prior to or at the time of admission, these indicators are reported Yes.

Example: Acute and chronic bronchitis 466.0 Y and 491.9 Y, respectively

If an acute exacerbation of a chronic condition is identified during the current inpatient admission, the acute condition indicator is reported no and the chronic condition indicator is reported Yes.

Example: Acute and chronic bronchitis 466.0 N and 491.9 Y, respectively

When there are no separate ICD-9-CM codes for conditions that are described as both acute and chronic, the indicator is reported as follows:

If acute and chronic conditions are both present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: COPD with acute exacerbation 491.21 Y.

If an acute exacerbation of a chronic condition developed during the current inpatient admission, the indicator is reported No.

Example: Diabetes mellitus with ketoacidosis 250.10 N.

Indicators for signs and symptoms, rule out or suspected conditions, comparative/contrasting conditions, symptoms followed by comparative/contrasting conditions, and abnormal findings:

If a sign or symptom is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Nausea with vomiting 787.01 Y.

If a suspected condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Rule out sepsis 038.9 Y.

If two or more comparative or contrasting conditions are present prior to or at the time of the current inpatient admission, the indicators are reported Yes.

Example: Diverticulitis versus appendicitis 562.11 Y and 541 Y, respectively.

If a symptom followed by comparative or contrasting conditions is present prior to or at the time of the current inpatient admission, all indicators are reported Yes.

Example: Chills, pneumonia versus. bladder infection 780.9 Y, 486 Y, and 595.9 Y, respectively

If a threatened or impending condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Threatened abortion 640.03 Y.
Impending myocardial infarction 411.1 Y.

If an abnormal finding is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Hyponatremia 276.1 Y.

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Suspected postoperative infection 998.59 N.

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported uncertain.

Example: Possible urinary tract infection was diagnosed during the stay. Patient receiving antibiotics for cholecystitis prior to admission 599.0 U.

Indicators for Obstetrical Conditions:

If an antepartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported yes.

Example: Pregnancy with fetal distress 656.33 Y.

If a chronic condition during delivery is present prior to or at the time of the current inpatient admission, the indicator is reported yes.

Example: Pregnancy with diabetes, delivered 648.01 Y.

If a postpartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Third degree perineal laceration following delivery at home 664.24 Y.

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Postpartum fever, delivered 670.02 N.

If an acute condition develops during delivery and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No.

Example: Third degree perineal laceration during delivery 664.21 N.

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Delivery and breast abscess diagnosed during stay 675.11 U.

Indicators for V Codes:

If a V code identifies a birth or an outcome of delivery at the time of the current inpatient admission, the indicator is reported Yes.

Example: Newborn V30.00 Y.
Single liveborn infant V27.0 Y.

If a V code identifies the reason for admission at the time of the current inpatient admission, the indicator is reported Yes.

Example: Admission for chemotherapy V58.1 Y.

If a V code identifies a history or status at the time of the current inpatient admission, the indicator is reported Yes.

Example: Status colostomy V44.3 Y

If a V code identifies a problem that develops during the current inpatient admission, the indicator is reported No.

Example: Canceled surgery V64.1 N

If a V code identifies exposure to a communicable disease during the current inpatient admission, the indicator is reported No.

Example: Exposure to strep throat during current admission V01.8 N

If a V code identifies a situation and it is not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

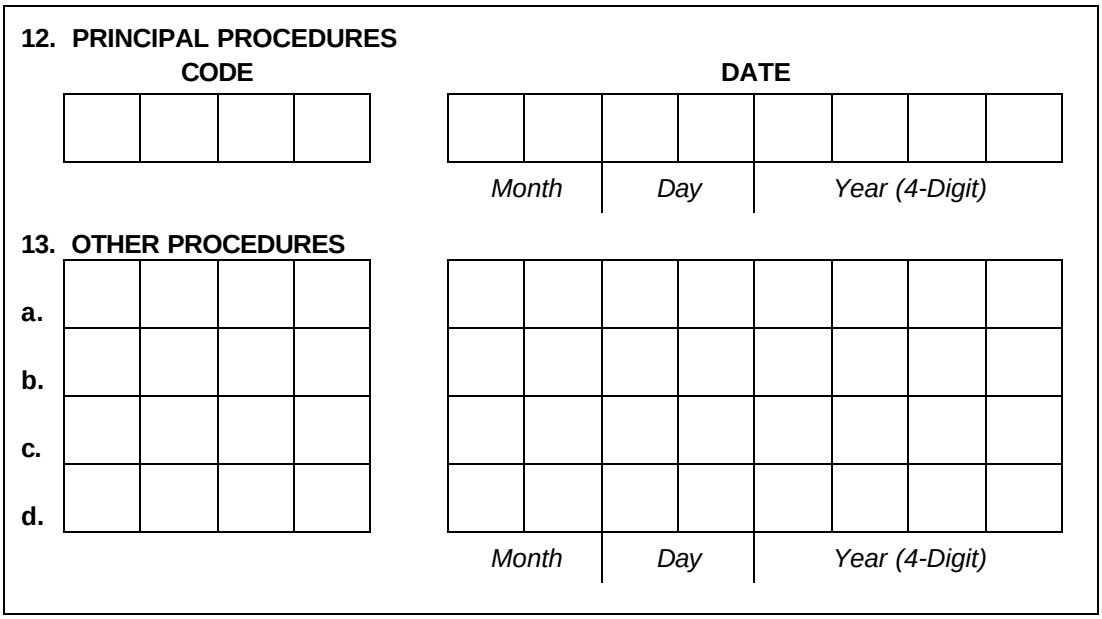
Example: Family disruption V61.0 U

OTHER PROCEDURES AND DATES — Section 97229

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. Procedures shall be coded according to the ICD-9-CM. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Reporting Requirements:

- A date will be reported for all other procedures reported. If the other procedure was performed on September 12, 1999, the reported value is 09121999.
- Other procedures and dates will be blank if no principal procedure is reported.

ICD-9-CM Codes: Refer to the definitions of a significant procedure in the *Coding Clinic for ICD-9-CM*, July - August 1985 and Fourth Quarter 1990, and the Universal Hospital

Discharge Data Set (UHDDS) published in the Federal Register, Volume 50, Number 147, July 31, 1985.
Other Coding Systems: HCPCS and CPT codes are not accepted by OSHPD.

Number of Other Procedures and Dates: Up to twenty other procedures and dates may be reported to OSHPD.

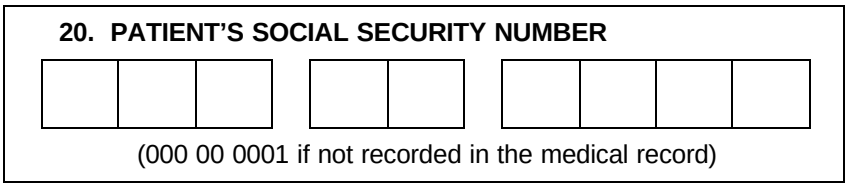
Ambulatory Surgery Facility and Hospital Outpatient Services: Patients are sometimes admitted within 72 hours of procedures performed in a licensed ambulatory surgery facility or as an outpatient at a hospital. Under certain circumstances, the procedure may be reported on the discharge data record. If so, the procedure date must be reported when it actually occurred and not be changed to the admission date. OSHPD accommodates procedure dates three days prior to the admission date.

PATIENT SOCIAL SECURITY NUMBER — Section 97220

The patient's social security number is to be reported as a 9-digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record," by reporting the social security number as "000000001." The number to be reported is to be the patient's social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital's bill is to be submitted.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Requirement for the SSN in Hospitals: Licensing and Certification of the Department of Health Services requires that the patient's SSN, if available, be recorded as part of the content of the medical record (Section 70749, Title 22, California Code of Regulations).

The SSN was added to the California Hospital Discharge Data Set (CHDDS) as an identifier to link episodes of care over time and across providers in order to support research addressing the quality of medical care in California hospitals. A unique personal identifier can also assist policy makers and researchers (e.g., number of patients admitted for a specific condition). OSHPD continues to consider the protection of individually identifiable medical information as the crux of its legislative mandate.

The SSN is confidential and is encrypted into a nine-digit alphanumeric identifier, the Record Linkage Number (RLN). The RLN is available on public data sets because the SSN from which it is derived cannot be determined.

Non-U.S. Numbers: Even if a non-U.S. number resembles a U.S. SSN, do not report it to OSHPD.

SSN for Patient Only:

- Mother's SSN is not the newborn's SSN.
- Parent's SSN is not a child's SSN.
- Husband's SSN is not a wife's SSN.

Valid/Invalid SSNs: SSNs consist of nine digits divided into three parts. The first three digits

denote the area (or state) where the application was filed. The middle two digits denote a group number ranging from 01 to 99. The last four digits are the serial number. Because of the way the SSN is constructed, it is possible to say that a particular SSN is invalid if it starts with three digits not approved by the Social Security Administration for use as an area identifier or if it has 00 in the group number area. Please refer to the current version of OSHPD's Editing Criteria Handbook for valid/invalid area identifier numbers.

Validation: Semiannually, OSHPD verifies the area (or state) digits with the local office of the Social Security Administration.

Medicare Numbers: The Medicare program is a federal health insurance program for individuals 65 years and older and certain disabled individuals. The number issued for Medicare coverage is a Health Insurance Benefit/Claim (HIB/HIC) number. The HIB/HIC number usually has nine digits and one or two letters, and there may also be another number after the letter(s). There are no dashes or spaces in the HIB/HIC number. SSNs and HIB/HIC numbers are not interchangeable. The first nine digits of the HIB/HIC number may be, but are not always, the same as the nine digits of the SSN.

PREHOSPITAL CARE AND RESUSCITATION / DNR (Do Not Resuscitate) Section 97233

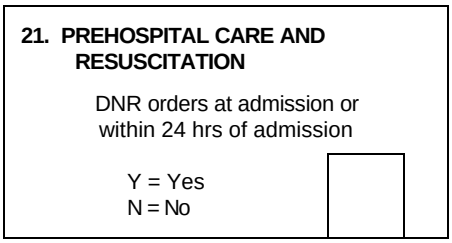
Effective with discharges on or after January 1, 1999, information about resuscitation orders in a patient's current medical record shall be reported as follows:

(a) Yes, a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital.

(b) No, a DNR order was not written at the time of or within the first 24 hours of the patient's admission to the hospital.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



DISCUSSION

See Subsection (f) of Section 97212 of the CCR for the definition of a DNR order.

A Do Not Resuscitate (DNR) order is a directive from a physician documented in a patient's current inpatient record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. The directive will be a physicians order, dated and signed. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following:

- cardiopulmonary resuscitation (CPR)
- intubation
- defibrillation
- cardioactive drugs
- assisted ventilation

If a DNR order is written at the time of or within the first 24 hours of the patient's admission to the hospital and is then discontinued at some later time during the patient's hospital stay, report "Yes" to OSHPD.

PRINCIPAL DIAGNOSIS AND WHETHER THE CONDITION WAS PRESENT AT ADMISSION

Section 97225

(a) The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-9-CM.

(b) Effective with discharges on or after January 1, 1996, whether the patient's principal diagnosis was present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

10. PRINCIPAL DIAGNOSIS CODE					10a. PRESENT AT ADMISSION	
						Y = Yes N = No U = Uncertain
11. OTHER DIAGNOSES					**11a. PRESENT AT ADMISSION**	
a.						
b.						
c.						
d.						

Principal Diagnosis:

Reporting Requirement: A principal diagnosis must be reported for every discharge data record.

Other Coding Systems:

- Morphology Codes are not accepted by OSHPD.
- SNODO codes are not accepted by OSHPD.
- DSM-IV codes are not accepted by OSHPD.

ICD-9-CM Codes:

Refer to the official guidelines for coding and reporting the principal diagnosis in *Coding Clinic for ICD-9-CM.*

Codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) will never be reported in the principal diagnosis code field. Such codes must only be reported in the External Causes of Injury code fields.

Italicized codes will never be the principal diagnosis.

Mothers who deliver their babies in outpatient clinics (e.g., ABC) or emergency rooms, and who then are admitted to inpatient care, will have a principal diagnosis reflecting the reason for admission, such as postpartum observation (V24) or postpartum complication (640-676) with fifth digit of 4.

Condition Present at Admission for Principal Diagnosis:

Purpose:

The purpose of collecting the data element Condition Present at Admission is to differentiate between conditions present at admission and conditions that developed during an inpatient admission. The focus is to assess the timing of when the condition was present.

Reporting Requirements:

- Each principal diagnosis and all other diagnoses must have an indicator for reporting whether or not a condition is present at admission by choosing one of the following responses:

  Yes

  No

  Uncertain

- The ICD-9-CM E-codes, external causes of injury and poisoning, are excluded from this reporting requirement.

Parameters for Reporting:

If the physician states that a condition is present (Y) or not present (N) at admission or is uncertain (U) whether or not the condition was present at admission, the physician's statement takes precedence over the following parameters.

A condition is considered present at admission if it is identified in the history and physical examination or documented in the current inpatient medical records (e.g., emergency room, initial progress, initial nursing assessment, clinic/office notes).

When a condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes (Y).

When a condition develops during the current inpatient admission and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No (N).

When it is not clearly indicated that a condition is present at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain (U).

Coding professionals will need to use their best judgment to determine whether or not a condition is present at the time of the current inpatient admission. If there is doubt as to whether or not the condition is present at admission, coding professionals are encouraged to ask the physician.

Assignment of Indicator for Principal Diagnosis:

- If the principal diagnosis indicator is blank, OSHPD will assign Yes (Y).
- If the error tolerance level for principal diagnosis indicators (invalids) is less than .1% after being corrected by the hospital, OSHPD will default the invalid indicators to Yes (Y).

Indicators for Acute and Chronic Conditions:

Chronic conditions that may not have been identified prior to or at the time of the current inpatient admission would be considered to have been present at admission. The indicator for the chronic condition is reported Yes.

Example: Lung cancer discovered during admission 162.9 Y

When there are separate ICD-9-CM codes for some conditions that are described as both acute and chronic, the indicators are reported separately as follows:

If acute and chronic conditions are both present prior to or at the time of admission, these indicators are reported Yes.

Example: Acute and chronic bronchitis 466.0 Y and 491.9 Y, respectively

If an acute exacerbation of a chronic condition develops during the current inpatient admission, the acute condition indicator is reported No and the chronic condition indicator is reported Yes.

Example: Acute and chronic bronchitis 466.0 N and 491.9 Y, respectively

When there are no separate ICD-9-CM codes for conditions that are described as both acute and chronic, the indicator is reported as follows:

If acute and chronic conditions are both present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: COPD with acute exacerbation 491.21 Y

If an acute exacerbation of a chronic condition developed during the current inpatient admission, the indicator is reported No.

Example: Diabetes mellitus with ketoacidosis 250.10 N

Indicators for signs and symptoms, rule out or suspected conditions, comparative/contrasting conditions, symptoms followed by comparative/contrasting conditions, and abnormal findings:

If a sign or symptom is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Nausea with vomiting 787.01 Y

If a suspected condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Rule out sepsis 038.9 Y

If two or more comparative or contrasting conditions are present prior to or at the time of the current inpatient admission, the indicators are reported Yes.

Example: Diverticulitis versus appendicitis 562.11 Y and 541 Y, respectively.

If a symptom followed by comparative or contrasting conditions is present prior to or at the time of the current inpatient admission, all indicators are reported Yes.

Example: Chills, pneumonia vs bladder infection 780.9 Y, 486 Y, and 95.9 Y, respectively.

If a threatened or impending condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Threatened abortion 640.03 Y
Impending myocardial infarction 411.1 Y

If an abnormal finding is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Hyponatremia 276.1 Y

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Suspected postoperative infection 998.59 N

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

Example: Possible urinary tract infection was diagnosed during the stay. Patient receiving antibiotics for cholecystitis prior to admission 599.0 U

Indicators for Obstetrical Conditions:

If an antepartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Pregnancy with fetal distress 656.33 Y

If a chronic condition during delivery is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Pregnancy with diabetes, delivered 648.01 Y

If a postpartum condition is present prior to or at the time of the current inpatient admission, the indicator is reported Yes.

Example: Third degree perineal laceration following delivery at home 664.24 Y

If the above conditions are not present at the time of the current inpatient admission, the indicator is reported No.

Example: Postpartum fever, delivered 670.02 N

If an acute condition develops during delivery and it is not present prior to or at the time of the current inpatient admission, the indicator is reported No.

Example: Third degree perineal laceration during delivery 664.21 N

If the above conditions are not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported uncertain.

Example: Delivery and breast abscess diagnosed during stay 675.11 U

Indicators for V Codes:

If a V code identifies a birth or an outcome of delivery at the time of the current inpatient admission, the indicator is reported Yes.

Example: Newborn V30.00 Y
Single liveborn infant V27.0 Y

If a V code identifies the reason for admission at the time of the current inpatient admission, the indicator is reported Yes.

Example: Admission for chemotherapy V58.1 Y

If a V code identifies a history or status at the time of the current inpatient admission, the indicator is reported Yes.

Example: Status colostomy V44.3 Y

If a V code identifies a problem that develops during the current inpatient admission, the indicator is reported No.

Example: Canceled surgery V64.1 N

If a V code identifies exposure to a communicable disease during the current inpatient admission, the indicator is reported No.

Example: Exposure to strep throat during current admission V01.8 N

If a V code identifies a situation and it is not clearly indicated as being present either at the time of the current inpatient admission or developing during the current inpatient admission, the indicator is reported Uncertain.

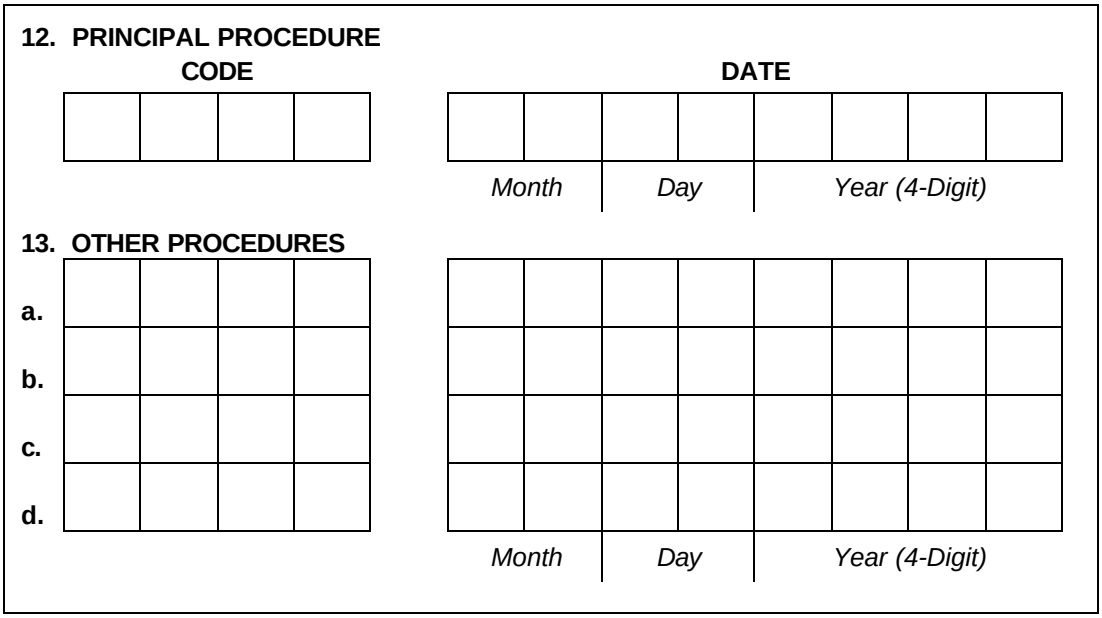
Example: Family disruption V61.0 U

PRINCIPAL PROCEDURE AND DATE — Section 97228

The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Reporting Requirement: The date of the principal procedure will be reported. If the principal procedure was performed on June 6, 1999, the reported value is 06061999.

ICD-9-CM Codes: Refer to the definitions of a significant procedure in the *Coding Clinic for ICD-9-CM*, July - August 1985 and Fourth Quarter 1990, and the UHDDS published in the Federal Register, Volume 50, Number 147, July 31, 1985.

Other Coding Systems: HCPCS and CPT codes are not accepted by OSHPD.

Ambulatory Surgery Facility and Hospital Outpatient Services: Patients are sometimes admitted within 48 hours of procedures performed in a licensed ambulatory surgery facility or as an outpatient at a hospital. Under certain circumstances, the procedure may be reported on the discharge data record. If so, the procedure date must be reported when it actually occurred and not be changed to the admission date. OSHPD accommodates procedure dates three days prior to the admission date.

RACE **Section 97218**

Effective with discharges on January 1, 1995, the patient's ethnic and racial background shall be reported as one choice from the following list of alternatives under ethnicity and one choice from the following list of alternatives under race:

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

4. RACE

ETHNICITY		RACE			
1 Hispanic		1 White		4 Asian/Pacific Islander	
2 Non-Hispanic		2 Black		5 Other	
3 Unknown		3 Native American/ Eskimo/Aleut		6 Unknown	

Race/Ethnicity data is most accurate when the patients are asked to identify their own race and ethnicity. Self-identification may include the use of a form displaying race/ethnicity choices. Data quality deteriorates when assumptions based on the patient's or a family member's name, physical appearance, place of birth, or primary language are the basis for the determination of race and ethnicity data.

(a) Ethnicity:

(1) Hispanic. A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

(2) Non-Hispanic.

(3) Unknown.

DISCUSSION

This category includes patients who cannot or refuse to declare ethnicity.

(b) Race:

(1) White. A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East.

(2) Black. A person having origins in or who identifies with any of the black racial groups of Africa.

(3) Native American/Eskimo/Aleut. A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

(4) Asian/Pacific Islander. A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

DISCUSSION

To bridge the gap between geography and specific names that may be used to describe Asians, the following list of Asian and Pacific Islander groups reported in the 1990 U.S. Census is provided: Asian Indian (as opposed to American Indians), Bangladeshi, Bhutanese, Borneo, Burmese, Celebesian, Chinese, Fijian, Filipino (Philippine), Formosan, Guamanian, Hawaiian, Hmong, Indochinese, Indonesian, Iwo-Jiman, Japanese, Javanese, Korean, Laotian, Malayan, Malvidian, Melanesian, Micronesian, Nepali, Okinawan, Pakistani, Papua New Guinean, Polynesian, Samoan, Sikkim, Singaporean, Solomon Islander, Sri Lankan, Sumatran, Tahitian, Taiwanese, Thai (Thailand), Tibetan, Tongan, and Vietnamese.

(5) Other. Any possible options not covered in the above categories.

DISCUSSION

This category includes patients who cite more than one race.

(6) Unknown.

DISCUSSION

This category includes patients who cannot or refuse to declare race.

ADDITIONAL DISCUSSION FOR ALL CATEGORIES

Determining Ethnicity and Race:

- Hispanic origin or descent is not to be confused with race. A person of Hispanic origin may be of any race.
- The patient's ethnicity and race data may be most accurately obtained directly from the patient. Self-identification may include the use of a form presenting choices.
- The quality of ethnicity and race data deteriorates when determination is based upon the patient's or a family member's name, physical appearance, place of birth, or primary language.
- If the patient is unable to respond, a family member may declare the patient's ethnicity and race.

Ethnicity and Race of a Newborn: The parent(s) declares the ethnicity and race of a newborn. If the parent(s) is unable or unwilling to declare the newborn's race, it is appropriate to report the ethnicity and race of the mother for that of the newborn.

Multiracial Persons:

If a patient identifies with more than one of OSHPD's race categories:

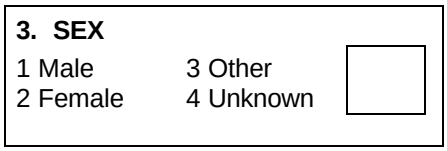
- It may be appropriate for the patient to choose any one of the categories that is at least partially accurate.
- It may be appropriate for the patient to choose "Other."

SEX **Section 97217**

The patient's gender shall be reported as male, female, other, or unknown. "Other" includes sex changes, undetermined sex, and live births with congenital abnormalities that obscure sex identification. "Unknown" indicates that the patient's sex was not available from the medical record.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Whenever a diagnosis is sex specific, the reported sex must be consistent with the reported ICD-9-CM diagnosis code.

SOURCE OF ADMISSION — Section 97222

Effective with discharges on or after January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			

(a) The site from which the patient was admitted.

(1) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

DISCUSSION

See Examples 1, 2, 3, 14, 15, and 16 at the end of this section.

This category includes:

- Patients admitted from a home environment (e.g., half-way house, group home, community care facility, foster care, women's shelter, mother who delivers at an ABC).
- The mother who delivers at home and the baby born at home.

Homeless persons, who by definition lack a residence, may nevertheless appropriately be admitted from this category. Use SOA Site "Home" to indicate that the patient came from a site not included in the license of any hospital.

2) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

DISCUSSION

See Example 24 and at the end of this section.

This category includes patients admitted from:

- Various types of facilities that provide supportive and custodial care. The facilities are licensed by the California Department of Social Services and are not considered to be health facilities. The facilities are referred to by a variety of terms (e.g., board and care, residential care facilities for the elderly).
- MHRCs. See Glossary of Terms and Abbreviations (Appendix A) for definition.

(3) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

DISCUSSION

See Examples 17 and 18 at the end of the section.

This category includes patients admitted from an out of state, federal, or foreign licensed ambulatory surgical facility.

(4) Skilled Nursing/Intermediate Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility, as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

DISCUSSION

See Examples 9, 10, 11, 12, and 13 at the end of the section.

This category includes patients admitted from:

- A skilled nursing bed for the Medi-Cal Subacute Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- A skilled nursing bed for the Medi-Cal Transitional Care Program. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An acute care bed that is used to provide skilled nursing care in an approved swing bed program.
- A California Department of Corrections (prison) skilled nursing facility.
- An out of state, federal, or foreign hospital.
- An IMD. See Glossary of Terms and Abbreviations (Appendix A) for definition.

(5) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of a hospital.

DISCUSSION

See Examples 19 and 20 at the end of the section.

This category includes patients admitted from:

- A California Department of Corrections (prison) hospital.
- An acute care bed for the Medi-Cal Subacute Care Program at another hospital only. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An acute care bed for the Medi-Cal Transitional Care Program at another hospital only. See Glossary of Terms and Abbreviations (Appendix A) for definition.
- An out of state, federal, or foreign hospital.

(6) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

DISCUSSION

See Examples 21, 22, and 23 at the end the section.

This category includes patients admitted from an out of state, federal, or foreign hospital.

(7) Newborn. A baby born alive in this hospital.

DISCUSSION

See Example 8 at the end of the section.

This category includes newborns born in your hospital with a principal diagnosis code of V30-V39 with the fourth digit of 0.

This category excludes infants with a principal diagnosis code of V30-V39 with the fourth digit 1 (born before admission to hospital).

(8) Prison/Jail. A patient admitted from a correctional institution.

DISCUSSION

This category includes patients admitted from juvenile hall.

This category excludes patients admitted from Department of Corrections (prison) hospitals.

(9) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from a freestanding, not hospital-based, inpatient hospice facility.

DISCUSSION

See Examples 4, 5, 6, and 7 at the end of the section.

This category includes some infants born before admission to the hospital.

Born before admission to hospital includes, but is not limited to, an infant born at the following sites:

Automobile	Your or another hospital's:
Taxicab	Emergency room
Ambulance	Waiting room
ABC or other outpatient clinic	Elevator
Physician's office	Lobby
Retail store	Parking lot

This category excludes infants born at home before admission to hospital and patients admitted from a federal hospital.

(b) Licensure of the site.

DISCUSSION

The categories refer to whether the place from which the patient was admitted is included on the admitting hospital's license, some other hospital's license, or is not included in the license of any hospital.

If your facility's licensure is unknown, contact OSHPD.

If a site's licensure is unknown, ask someone at the site whether it is licensed as part of another hospital or whether it is freestanding.

(1) This Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

DISCUSSION

See Examples 4, 8, 10, 12, 18, 19, 21, and 22 at the end of the section.

This category also includes babies born in your hospital's ER before admission to hospital.

This category includes patients admitted from a consolidated hospital that has elected to submit one discharge data report to OSHPD. Admitted from a:

- TOC 1 bed to a TOC 3, 4, 5, or 6 bed.
- TOC 3 bed to a TOC 1, 4, 5, or 6 bed.
- TOC 4 bed to a TOC 1, 3, 5, or 6 bed.
- TOC 5 bed to a TOC 1, 3, 4, or 6 bed.
- TOC 6 bed to a TOC 1, 2, 3, or 5 bed.

(2) Another Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

DISCUSSION

See Examples 6, 9, 13, 20, and 23 at the end of the section.

This category includes patients admitted from a consolidated hospital that has elected to submit two or more discharge data reports to OSHPD.

This category includes babies born in another hospital's ER before admission to your hospital.

This category includes patients admitted from another state, a federal, or a foreign hospital. Federal hospitals may include Veterans Administration, Department of Defense, or Public Health Service hospitals.

(3) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Skilled Nursing/Intermediate Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

DISCUSSION

See Examples 1, 2, 3, 5, 7, 11, 14, 15, 16, 17, and 24, at the end of the section.

This category includes patients admitted from:

Home
Street
Residential Care Facility
Freestanding nursing home
Freestanding licensed ambulatory surgery facility
ABCs or other outpatient clinic
Automobile
Taxicab
Ambulance
Retail store
Physician's office

Your or another hospital's:
Waiting room
Elevator
Lobby
Parking lot

(c) Route of admission.

(1) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of another hospital.

DISCUSSION

See Examples 1, 2, 4, 7, 9, 14, 15, and 17 at the end of the section.

(2) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

DISCUSSION

See Examples 3, 5, 6, 8, 10, 11, 12, 13, 16, 18, 19, 20, 21, 22, 23, and 24 at the end of the section.

EXAMPLES OF SOURCE OF ADMISSION (SOA)

EMERGENCY ROOM

1. John arrives at Hospital A and is seen in the Emergency Room (ER). He is referred to your hospital, Hospital B. He is seen in your ER and is admitted.

   Q. What is John's Source Of Admission at your hospital?

   A. John was not an inpatient at Hospital A so his SITE would be "Home"(1). "Home" is an unlicensed location so the LICENSURE OF SITE would be "Not a Hospital" (3) John was seen in your ER so ROUTE would be "Your ER" (1), which is reported as shown below.

   John's Source of Admission would be reported as "Home" if he were a homeless person because "home" refers to many sites that are not included on the license of any hospital.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

2. Jane arrives at Hospital A and is seen in the ER. Hospital A arranges for Jane to be admitted to your hospital. She is sent to your hospital by ambulance and admitted.

   Q. What is Jane's Source Of Admission at your hospital?

   A. Jane was not an inpatient at Hospital A, and her visit to the ER of Hospital A is irrelevant to reporting SOA at your hospital, so her SITE would be "Home"(1). "Home" is an unlicensed location so the LICENSURE OF SITE would be "Not a Hospital" (3). Jane was seen in your ER so ROUTE would be "Your ER" (1), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

INFANT BORN AT HOME

3. Alexi is born at home. Alexi and his mother are taken by ambulance to your hospital and admitted.

   Q. What is Alexi's Source Of Admission at your hospital?

   A. His SITE would be "Home"(1). "Home" is an unlicensed location so the LICENSURE OF SITE would be "Not a Hospital" (3). He was not seen in your ER so ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
1		**3**	**2**

EXAMPLES OF SOURCE OF ADMISSION (SOA)

BORN BEFORE ADMISSION

4. Sue is born in the ER at your hospital before her mother is admitted. Sue is admitted to the nursery.

   Q. What is Sue's Source Of Admission at your hospital?

   A. Her SITE would be "Other"(9). because Sue was born within the hospital but before admission (refer to the definition of "Other"). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Your ER" (1), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
9		**1**	**1**

5. Gene is born in a taxicab. Baby Gene develops complications and is admitted to your hospital.

   Q. What is newborn Gene's Source Of Admission at your hospital?

   A. His SITE would be "Other"(9). because Gene was born before admission to the hospital (refer to the definition of "Other"). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
9		**3**	**2**

EXAMPLES OF SOURCE OF ADMISSION (SOA)

BORN BEFORE ADMISSION

6. Carol is born in the ER of Hospital A which does not have a perinatal unit. Carol is transferred to your hospital and admitted directly to the nursery.

   Q. What is Carol's Source Of Admission at your hospital?

   A. Her SITE would be "Other"(9). because Carol was born before admission to the hospital (refer to the definition of "Other"). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home	6 Other Inpatient Hospital Care		1 This Hospital		1 Your ER	
2 Residential Care Facility	7 Newborn	9	2 Another Hospital	2	2. Not Your ER (or no ER)	2
3 Ambulatory Surgery	8 Prison/Jail		3 Not a Hospital			
4 SN/IC	9 Other					
5 Acute Inpatient Hospital Care						

7. Kristin is born in her parents' automobile on the way to the hospital. She is seen in your ER and admitted.

   Q. What is Kristin's SOA at your hospital?

   A. Her SITE would be "Other"(9). because Kristen was born before admission to the hospital (refer to the definition of "Other"). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home	6 Other Inpatient Hospital Care		1 This Hospital		1 Your ER	
2 Residential Care Facility	7 Newborn	9	2 Another Hospital	3	2. Not Your ER (or no ER)	1
3 Ambulatory Surgery	8 Prison/Jail		3 Not a Hospital			
4 SN/IC	9 Other					
5 Acute Inpatient Hospital Care						

EXAMPLES OF SOURCE OF ADMISSION (SOA)

NEWBORN, BORN IN HOSPITAL

8. Jessica is admitted to your hospital and delivers twins by C-section.

   Q. What is the SOA for each newborn twin at your hospital?

   A. Each twin's SITE would be "Newborn"(7). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home	6 Other Inpatient Hospital Care		1 This Hospital		1 Your ER	
2 Residential Care Facility	7 Newborn	7	2 Another Hospital	1	2. Not Your ER (or no ER)	2
3 Ambulatory Surgery	8 Prison/Jail		3 Not a Hospital			
4 SN/IC	9 Other					
5 Acute Inpatient Hospital Care						

SKILLED NURSING / INTERMEDIATE CARE

9. June is an inpatient in the skilled nursing facility at a Psychiatric Hospital. She compains of abdominal pain. She is taken to your hospital, examined in the ER, and admitted to acute care.

   Q. What is June's SOA at your hospital?

   A. June's SITE would be "SN/IC"(4). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Your ER" (1), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home	6 Other Inpatient Hospital Care		1 This Hospital		1 Your ER	
2 Residential Care Facility	7 Newborn	4	2 Another Hospital	2	2. Not Your ER (or no ER)	1
3 Ambulatory Surgery	8 Prison/Jail		3 Not a Hospital			
4 SN/IC	9 Other					
5 Acute Inpatient Hospital Care						

EXAMPLES OF SOURCE OF ADMISSION (SOA)

SKILLED NURSING / INTERMEDIATE CARE

10. Julie is an inpatient in the skilled nursing facility of your hospital. She complains of pain and is transferred to acute care at your hospital.

    Q. What is Julie's Source Of Admission for her acute care record at your hospital?

    A. Julie's SITE would be "SN/IC"(4). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
4		**1**	**2**

11. Roger is an inpatient in a freestanding nursing home. He is taken to Hospital A and seen in the ER. Roger should be admitted but Hospital A is full and transfers Roger to your hospital. At your hospital, Roger is admitted directly to acute care.

    Q. What is Roger's Source Of Admission for his acute care record at your hospital?

    A. Roger's SITE would be "SN/IC"(4). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), which is reported as shown below. (Roger was not admitted to Hospital A, so his SITE would be the nursing home. His ER visit at Hospital A cannot be reported as ER at your hospital).

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
4		**3**	**2**

EXAMPLES OF SOURCE OF ADMISSION (SOA)

SKILLED NURSING / INTERMEDIATE CARE – CONSOLIDATED, ONE REPORT

A **CONSOLIDATED HOSPITAL** that submits **ONE REPORT** with one Hospital Identification Number:

12. Isabel is an inpatient in the skilled nursing facility of your hospital. She is transferred to acute care at your hospital.

    Q. What is Isabel's Source Of Admission for her acute care record at your hospital?

    A. Isabel's SITE would be "SN/IC"(4). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
4		**1**	**2**

SKILLED NURSING / INTERMEDIATE CARE – CONSOLIDATED, TWO REPORTS

For a CONSOLIDATED HOSPITAL that submits TWO OR MORE REPORTS with separate Hospital Identification Numbers:

13. Jason is an inpatient in the skilled nursing facility of your hospital. He is transferred to acute care at your hospital.

    Q. What is Jason's Source Of Admission for his acute care record at your hospital?

    A. Jason's SITE would be "SN/IC"(4). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
4		**2**	**2**

HOME

14. Shantelle has outpatient surgery at a licensed Ambulatory Surgery Center and returns home. Later she arrives in your ER and is admitted.

    Q. What is Shantelle's Source Of Admission at your hospital?

    A. Shantelle's SITE would be "Home" (1). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
1		**3**	**1**

15. Ray was an inpatient at Hospital A and was discharged home. Later Ray is seen in your ER and is admitted as an inpatient.

    Q. What is Ray's Source Of Admission at your hospital?

    A. Ray's SITE would be "Home" (1). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
1		**3**	**1**

EXAMPLES OF SOURCE OF ADMISSION (SOA)

OBSERVATION

16. Tonya is an outpatient in the observation unit of your hospital. Later she is admitted to acute care at your hospital.

    Q. What is Tonya's Source Of Admission at your hospital?

    A. Tonya's SITE would be "Home" (1). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	1	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	2

AMBULATORY SURGERY

17. During Chelsea's surgery at a licensed Ambulatory Surgery Center complications develop, she is transported to the ER of your hospital, and is admitted.

    Q. What is Chelsea's Source Of Admission at your hospital?

    A. Chelsea's SITE would be "Ambulatory Surgery" (3). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Your ER" (1), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	3	1 This Hospital 2 Another Hospital 3 Not a Hospital	3	1 Your ER 2. Not Your ER (or no ER)	1

EXAMPLES OF SOURCE OF ADMISSION (SOA)

AMBULATORY SURGERY

18. During surgery at your hospital's licensed Ambulatory Surgery facility Sara has an adverse reaction and is admitted to the Intensive Care Unit at your hospital.

    Q. What is Sara's Source Of Admission at your hospital?

    A. Sara's SITE would be "Ambulatory Surgery" (3). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
3		**1**	**2**

ACUTE INPATIENT HOSPITAL CARE

19. Jacob, an inpatient in your acute care, is transferred to the skilled nursing distinct part of your hospital.

    Q. What is the Source Of Admission on Jacob's skilled nursing record at your hospital?

    A. Jacob's SITE would be "Acute Inpatient Hospital Care" (5). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
5		**1**	**2**

ACUTE INPATIENT / VA HOSPITAL

20. Thomas is transferred from a VA hospital to your hospital.

    Q. What is Thomas's Source Of Admission at your hospital?

    A. Thomas's SITE would be "Acute Inpatient Hospital Care" (5). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
5		**2**	**2**

REHABILITATION / OTHER INPATIENT HOSPITAL CARE

21. Sally is receiving inpatient physical rehabilitation care in your hospital. She is transferred to acute care at your hospital.

    Q. What is the Source Of Admission on Sally's acute care record at your hospital?

    A. Sally's SITE would be "Other Inpatient Hospital Care" (6). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE		LICENSURE OF SITE	ROUTE
1 Home	6 Other Inpatient Hospital Care	1 This Hospital	1 Your ER
2 Residential Care Facility	7 Newborn	2 Another Hospital	2. Not Your ER (or no ER)
3 Ambulatory Surgery	8 Prison/Jail	3 Not a Hospital	
4 SN/IC	9 Other		
5 Acute Inpatient Hospital Care			
6		**1**	**2**

EXAMPLES OF SOURCE OF ADMISSION (SOA)

PSYCHIATRIC / OTHER INPATIENT

22. Jack is receiving psychiatric care at your hospital. He is transferred to acute care at your hospital.

    Q. What is the Source Of Admission on Jack's acute care record at your hospital?

    A. Jack's SITE would be "Other Inpatient Hospital Care" (6). The LICENSURE OF SITE would be "This Hospital" (1) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	6	1 This Hospital 2 Another Hospital 3 Not a Hospital	1	1 Your ER 2. Not Your ER (or no ER)	2

23. A Psychiatric Hospital transfers Ralph to your hospital, where he is admitted.

    Q. What is the Source Of Admission on Ralph's acute care record at your hospital?

    A. Ralph's SITE would be "Other Inpatient Hospital Care" (6). The LICENSURE OF SITE would be "Another Hospital" (2) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

SITE			LICENSURE OF SITE		ROUTE	
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care	6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	6	1 This Hospital 2 Another Hospital 3 Not a Hospital	2	1 Your ER 2. Not Your ER (or no ER)	2

EXAMPLES OF SOURCE OF ADMISSION (SOA)

RESIDENTIAL CARE FACILITY

24. Bailey lives in a Residential Care Facility. He is admitted to inpatient care at your hospital.

Q. What is the Source Of Admission on Bailey's inpatient record at your hospital?

A. Bailey's SITE would be "Residential Care Facility" (2). The LICENSURE OF SITE would be "Not a Hospital" (3) and ROUTE would be "Not Your ER" (2), which is reported as shown below.

7. SOURCE OF ADMISSION

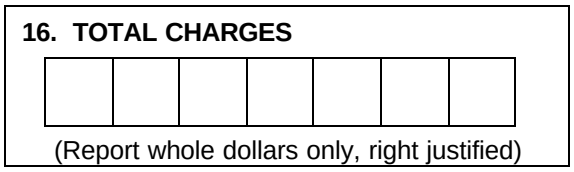
SITE		LICENSURE OF SITE	ROUTE
1 Home 2 Residential Care Facility 3 Ambulatory Surgery 4 SN/IC 5 Acute Inpatient Hospital Care 6 Other Inpatient Hospital Care 7 Newborn 8 Prison/Jail 9 Other	2	1 This Hospital 2 Another Hospital 3 Not a Hospital	1 Your ER 2. Not Your ER (or no ER)
		3	2

TOTAL CHARGES — Section 97230

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), report Total Charges for the last year (365 days) of stay only.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Reporting Requirements:

When there are no charges (no bill generated) for the hospital stay, $1 should be reported.

Charges should be rounded to the nearest dollar.

Charges for newborns must be reported on the newborn's discharge data record and excluded from the mother's discharge data record.

Total Charges are the amount billed for the stay at full established rates (before contractual adjustments).

Examples of charges to be included:

Daily hospital services
Ancillary services
Other services defined as patient care
Prepayments (e.g., deposits and prepaid admissions)
Bundled ambulatory surgery, outpatient, and/or observation charges
Late revenue adjustments

Examples of charges to be excluded:

- Hospital-based physician fees
- Medicare bed hold charges for skilled nursing care
- Television
- Telephone
- Guest trays
- Take-home drugs
- Video cassette recorder
- Follow-up home health visits

Length of Stay Greater than 365 Days:

Only total charges for the final 365 days are to be reported.

OSHPD divides reported total charges by 365 to find the average charge per day. This average charge per day is then multiplied by the length of stay. The result is the adjusted total charges, which is the amount appearing in OSHPD publications.

Seven Digit Format: OSHPD's standard format and specifications for reporting total charges requires seven digits (0000000 through 9999999); this allows a maximum charge for one patient of $9,999,999. A total charge of $99,999 or $999,999 indicates to OSHPD that the charges exceed the field size utilized by the hospital or designated agent.

Physician Professional Component: When the hospital bills patients for physician services and remits a fee to the physician, whether the fee is in the form of a salary or a percentage of the total charges, the fee must be excluded from total charges. This is necessary in order to obtain comparability of charge data on all hospitals.

Total Charges: Each episode of inpatient care must be reported.

Transfer Within the Hospital: Transfers between Types of Care Within the Hospital must be reported to OSHPD as two or more separate discharge data records, including separate total charges.

Total Package: A person admitted for a course of treatment (e.g., for psychological problems, substance abuse treatment, treatment of an eating disorder) is told that the payment covers the total package for all treatments and any later need for inpatient care for the same purpose (within a certain period of time). After the patient is discharged, a discharge record must be reported. If the patient is readmitted, another discharge record must be reported when the patient leaves the hospital, even if no additional charge will be made to the patient. The second and any subsequent record for this course of treatment would report total charges of $1 (no charge) to OSHPD.

Live Organ Donors: When a (live) person is admitted for the purpose of donating an organ, a discharge data record must be reported whether or not a charge is made. If no charge is made, report total charges of $1 (no charge).

Interim Billing: Some hospitals have a policy, for billing purposes, of discharging and readmitting their extended stay patients at the end of each month. Only one discharge data record must be reported to OSHPD. That one record must include charges for all days of inpatient care.

TYPE OF ADMISSION — Section 97223

Effective with discharges on January 1, 1995, the patient's type of admission shall be reported using one of the following categories:

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

(a) Scheduled. Admission was arranged with the hospital at least 24 hours prior to the admission.

DISCUSSION

See Examples 1 and 2, at the end of this section.

An admission is scheduled when arrangements are made 24 hours or more before the admission.

Pre-admission forms filled out by the patient or family and sent to the hospital do not constitute a scheduled admission; see Type of Admission (TOA) Example 3.

(b) Unscheduled. Admission was not arranged with the hospital at least 24 hours prior to the admission.

DISCUSSION

See Examples 3, 4, 5, and 6, at the end of this section.

An admission is unscheduled when arrangements are made less than 24 hours before the admission.

(c) Infant. An infant less than 24 hours old.

DISCUSSION

See Examples 7 and 8, at the end of this section.

This category includes newborns and all other neonates less than 24 hours old.
All records with the date of birth the same as the admission date must be reported as infant.

A patient with a date of birth two days or more before the admission date should not be reported as infant.

(d) Unknown. Nature of admission not known. Does not include stillbirths.

DISCUSSION

See Example 9, at the end of this section.

This category includes patients whose TOA cannot be determined as either scheduled or unscheduled.

EXAMPLES FOR TYPE OF ADMISSION FOR DISCHARGES STARTING 1/1/95

SCHEDULED

1. Helen is expected to deliver on April 1. Her physician schedules her admission for April 3 to induce labor. She is admitted on April 3. Report "Scheduled."

2. Henry is seen by his physician on March 15, and upon examination at 9:00 a.m. on March 15, it is determined that a cholecystectomy is necessary. He is scheduled for a cholecystectomy at 1:00 p.m. on March 16. He is admitted at 11:00 a.m. on March 16 for the scheduled cholecystectomy. Report "Scheduled."

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

1

UNSCHEDULED

3. June is expected to deliver on April 1. She goes to the hospital in labor and is admitted on that date. Even though the pre-admission forms may have been filled out months previously, Report "Unscheduled."

4. At 2:00 p.m. on March 14, Jack is examined, and it is determined that admission is necessary. He is scheduled for admission at 4:00 p.m. on March 15. Complications develop, and Jack is admitted at 11:00 a.m. on March 15. Report "Unscheduled."

5. Jason is scheduled two weeks in advance for surgery at your hospital's licensed ambulatory surgery facility. After surgery, complications develop in the recovery area, and he is admitted to inpatient care. Report "Unscheduled."

EXAMPLES FOR TYPE OF ADMISSION FOR DISCHARGES STARTING 1/1/95

UNSCHEDULED

6. On December 22, at 10:00 a.m., Mary's physician called the skilled nursing facility and made arrangements to transfer her from acute care at the hospital on December 23, at 2:00 p.m. On December 22, Mary is transferred to the skilled nursing facility at 4:00 p.m. because a bed became available early. Report "Unscheduled" at the skilled nursing facility.

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

2

INFANT

7. Heather is born at Hospital A and immediately (within 24 hours) is transferred to Hospital B's NICU. Both Hospital A and Hospital B Report Infant.

8. Glenda is born at home on July 10, at 3:00 a.m. On July 10, she develops jaundice and is admitted to the hospital at 11:00 p.m. Report Infant.

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

3

EXAMPLES FOR TYPE OF ADMISSION FOR DISCHARGES STARTING 1/1/95

UNKNOWN

9. Donna presents to the admitting office and states that her physician had previously scheduled her admission. The patient's information is in the reservation log; however, neither the date nor the time the call was taken is recorded. Report Unknown.

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

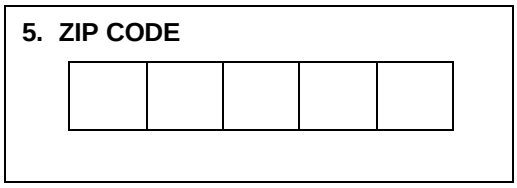
4

ZIP CODE **Section 97219**

The "ZIP Code," a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient's usual residence shall be reported for each patient discharge. Foreign residents shall be reported as "YYYYY" and unknown ZIP Codes shall be reported as "XXXXX." If the city of residence is known, but not the street address, report the first three digits of the ZIP Code, and the last two digits as zeros. Hospitals shall distinguish the "homeless" (patients who lack a residence) from other patients lacking a numeric ZIP Code of residence by reporting the ZIP Code of homeless patients as "ZZZZZ." If the patient has a 9-digit ZIP Code, only the first five digits shall be reported.

DISCUSSION

Format for reporting this data element on the Manual Abstract Reporting Form for discharges occurring on or after January 1, 1999:



Reporting Requirements:

- The ZIP Code of the usual residence of the patient must be reported.
- Report visitors from a foreign country as YYYYY.
- Report an unknown residence as XXXXX.
- Report homeless persons as ZZZZZ.
- If the city is known, but not the street, report the first three known digits and the last two digits as zero. Example: Sacramento, California, 95800
- Do not report the ZIP Code of the hospital, third party payer, or billing address if it is different from the usual residence of the patient.
- ZIP Codes may be verified by calling 1-800-ASK-USPS (1-800-275-8777)
- The web address is www.USPS.com.

REQUESTS

NOTE: The regulations are identified by bold and italics.

The section number located at the top right corner of the first page of each regulation refers to the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8.

REQUEST FOR MODIFICATION TO THE CALIFORNIA HOSPITAL DISCHARGE DATA SET

Section 97240

(a) Hospitals may file a request with the Office for modifications to the California Hospital Discharge Data Set. The modification request must be supported by a detailed justification of the hardship that full reporting of discharge data would have on the hospital; an explanation of attempts to meet discharge data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each hospital with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to discharge data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed healthcare decisions.

(2) The modification would not deprive the public of discharge data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

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REQUESTS FOR EXTENSION OF TIME TO FILE DISCHARGE DATA

Section 97241

Extensions are available to hospitals that are unable to complete their submission of discharge data reports by the due date prescribed in Section 97211. A maximum of 60 days is allowed for all extensions, corrections, and resubmittals. Hospitals are encouraged to file extension requests as soon as it is apparent that the required data will not be completed for submission on or before their due date. The request for extension shall be postmarked on or before the required due date of the discharge data report and supported by a letter of justification that may provide good and sufficient cause for the approval of the extension request. To provide the Office a basis to determine good and sufficient cause, the letter of justification shall include a factual statement indicating:

(1) the actions taken by the hospital to produce the discharge data report by the required deadline;

(2) those factors that prevent completion of the discharge data report by the deadline; and

(3) those actions and the time (days) needed to accommodate those factors.

The Office shall respond within 10 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. If disapproved, the Office shall set forth the basis for a denial in a notice to the hospital sent by certified mail. The Office may seek additional information from the requesting hospital. The Office shall not grant extensions that exceed an accumulated total of 60 days for all extensions and corrections of discharge data. If a hospital submits the discharge data report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A hospital that wishes to contest any decision of the Office shall have the right to appeal, pursuant to Section 97052.

DISCUSSION

As provided in Section 97045 any hospital that does not file a discharge data report by the due date is liable for a penalty of $100 a day for each day the discharge data report is late. Hospitals, not the designated agents, are responsible for filing an extension request to OSHPD. See Penalties and Appeals (Appendix B) Section 97045.

If an extension is not granted, penalties begin to accrue immediately upon the due date. If the due date has passed, hospitals can still request an extension. The penalty is limited to the days between the original due date and the date the extension is filed. An Extension Request (DD1805) is available in the Forms section of this Manual.

The maximum allowance of 60 extension days applies to the hospital's entire semiannual discharge data report. When hospitals consolidate their licenses, they are then limited to a

combined maximum of 60 extension days, whether or not a combined (single) discharge data report or multiple discharge data reports are submitted.

If the due date falls on a Saturday, Sunday, or holiday, the discharge data report or extension request may be filed the next business day without penalty. Extension days are calendar days, not working days. Requests for extension do not prevent or stop the accrual of penalties unless the extensions are granted by OSHPD.

If an extension is granted and the hospital submits the discharge data report in fewer days than allowed, OSHPD will consider only the extension days actually used.

The hospital is liable for penalties, despite any responsibility of designated agents.

When an extension request is filed after the due date and is granted, a $100 per day penalty is assessed against the hospital from the due date to the date the extension request was filed. When an extension request is denied, a $100 per day penalty is assessed from the due date to the date the discharge data report is filed.

When an extension request meets the criteria for granting extensions, the request will be granted and a letter will be sent to the hospital. When an extension request is denied, written notification of the denial and an explanation of the basis for the denial will be sent to the hospital by Certified Mail. A hospital may appeal the denial, as it may appeal a penalty. An appeal does not stop the accrual of penalty liabilities. When notices of penalties or denials of extension requests are mailed by OSHPD, appeal instructions are included.

APPENDICES

APPENDIX A

GLOSSARY
OF
TERMS AND ABBREVIATIONS

GLOSSARY OF TERMS AND ABBREVIATIONS

Acute Care – See General Acute Care.

Acute Psychiatric Hospital (APH). See Psychiatric Care.

Alternative Birth Center (ABC). A clinic that is not part of a hospital and that provides comparative prenatal services and delivery care to pregnant women who remain less than 24 hours at the facility, as defined by Subdivision (a)(4) of Section 1204 of the California Health and Safety Code.

Ambulatory Care. All types of health services provided to patients who are not confined to a hospital bed as an inpatient during the time services are rendered. Ambulatory services are often referred to as outpatient services.

Ancillary Services. Inpatient services other than basic room and board and professional services. Included are radiology, pharmacy, laboratory, emergency room, and home health.

Average Length of Stay (ALOS). Average stay by days of all or a class of inpatients discharged over a given period, calculated by dividing the number of inpatient days by the number of discharges.

Boarder. A person other than a patient, such as a parent, child, or spouse of an inpatient, who is temporarily housed in a hospital and who is not admitted to the hospital as an inpatient.

California Hospital Discharge Data Set (CHDDS). California's hospital discharge data set consisting of the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the California Health and Safety Code.

CHAMPUS. Civilian Health and Medical Program for the Uniformed Services, now TRICARE.

CHAMPVA. Civilian Health and Medical Program for the Veterans Administration.

Chemical Dependency Recovery Hospital. A health facility which provides 24-hr inpatient care for persons who have a dependency on alcohol or drugs. Care includes patient counseling, group and family therapy, physical conditioning, outpatient services, and dietetic services. The facility shall have a medical director who is a physician and surgeon licensed in California.

Clinic. A facility providing treatment to patients who do not require admission as inpatients.

Congregate Living Health Facility. A type of health facility licensed by the Department of Health Services and defined by Subdivision (i) of Section 1250 of the California Health and Safety Code. These are residential homes with a capacity of no more than six beds that provide inpatient care, medical supervision, and 24-hour skilled nursing care.

Consolidation. To formally combine two or more hospitals into a single licensed legal entity.

Designated Agent. The hospital's abstractor, an information services firm, or the information services department in the hospital's corporate office.

GLOSSARY OF TERMS AND ABBREVIATIONS

Diagnosis Related Group (DRG). A classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Healthcare Financing Administration.

Diagnostic and Statistical Manual of Mental Disorders (DSM). Diagnostic and statistical classification system produced by and available from the American Psychiatric Association, Washington, D.C.

Discharge. A newborn or person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer and who is discharged under one of the following circumstances:

- Is formally discharged from the care of the hospital and leaves the hospital.
- Transfers within the hospital from one level of care to another level of care.
- Has died.

Discharge Days. The total number of inpatient days between the admission and discharge dates of each patient. The day of admission but not the day of discharge is used in calculating discharge days. See Inpatient Days and Length of Stay.

Distinct Part. An identifiable unit accommodating beds and related facilities including, but not limited to, contiguous rooms, a wing, floor or building that is approved by the State Department of Health Services for a specific purpose, as defined by Section 70027 of the California Code of Regulations.

E-codes. Supplementary Classification of ICD-9-CM, containing External Causes of Injury and Poisoning.

Emergency Room/Department. A unit found in most hospitals that operates on a 24-hour basis and is organized to provide for unscheduled emergency outpatient services to individuals requiring immediate medical attention.

Exclusive Provider Organization (EPO). Identical to a PPO from which the phrase was derived, except that persons enrolled in the plan are eligible to receive benefits only when they use the services of the contracting providers.

Fax. Facsimile machine.

Freestanding. Not part of a hospital (neither structurally connected to nor organizationally considered part of a hospital); not hospital-based.

General Acute Care. Services provided to patient (on the basis of physicians' orders and approved nursing care plans) who are in an acute phase of illness but not to the degree which requires the

concentrated and continuous observation and care provided in the intensive care centers.

General Acute Care Hospital (GACH). A classification of hospital licensure, as defined by Subdivision (a) of Section 1250 of the California Health and Safety Code.

Geographic Origin. The geographic area of a patient, determined by a patient's ZIP Code. The ZIP Codes are then grouped by county, HFPA, and HSA.

Healthcare Financing Administration (HCFA). Component of the U.S. Department of Health and Human Services that administers the Medicare program and certain aspects of the Medicaid (California's Medi-Cal) program.

Health Facility. Any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer, as defined by Section 1250 of the California Health and Safety Code.

Health Facility Planning Area (HFPA). A geographic area that is a subdivision of an HSA, which are used for determining existing and needed hospital facilities and services.

Health Maintenance Organization (HMO). A healthcare organization that in return for prospective per capita (capitation) payments, acts as both insurer and provider of comprehensive but specified medical services. A defined set of physicians provide services to a voluntarily enrolled population.

Health Service Area (HSA). A geographic area consisting of one or more contiguous counties, previously designated by the U.S. Department of Health and Human Services for health planning on a regional basis.

Hill-Burton. A program of federal support for construction of hospitals and other health facilities which is no longer in existence. Some hospitals have a remaining community service obligation to provide free or community services.

GLOSSARY OF TERMS AND ABBREVIATIONS

Home Health Services. Healthcare provided to patients at their place of residence, at a level less intensive than health facility requirements. Services may include, but are not limited to, nursing care, intravenous therapy, respiratory/inhalation therapy, electrocardiology, physical therapy, occupational and recreational therapy, and hospice services.

Hospice. A hospice program is a centrally administered program of palliative and support services which provide psychological, social and spiritual care for dying persons and their families, focusing on pain and symptom control for the patient.

Hospital. Generally, an institution with an organized medical staff whose primary function is to provide diagnostic and therapeutic inpatient services for a variety of conditions, both surgical and non-surgical.

Hospital-based. Part of a hospital (either structurally or organizationally); not freestanding.

Individual Hospital Discharge Data Summary (IHDDS). Semiannual reporting period summary of the data elements reported to OSHPD for patients discharged by each California hospital.

Inpatient. A person who is admitted to a hospital or long-term care facility and who occupies a bed for treatment, generally for at least overnight. Some inpatients do not stay overnight since they die, are discharged, or are transferred from the hospital before midnight on the day of admission.

Inpatient Days. A measure of institutional use, usually measured as the number of inpatients at a specified time (e.g., midnight).

Institute for Mental Disease (IMD). A federal designation and not a California Department of Health Services License category. Most IMDs are licensed by the California Department of Health Services as skilled nursing facilities.

Intermediate Care. Long-term care that does not meet the standards for skilled nursing care, but is still nursing care, but is still classified as a health service. An intermediate care facility is defined by Section 1250 (d) of the Health and Safety Code.

Intermediate Care Facility (ICF). A health facility or a distinct part of a hospital or SNF that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous nursing care.

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Modification developed in the United States based on the official version of the World Health Organization's *International Classification of Diseases, 9th Revision*, and designed for classification of morbidity and mortality information for statistical reporting purposes and

information retrieval. Section 128735 of the California Health and Safety Code, requires that California hospitals use ICD-9-CM to report diagnoses, procedures, and E-codes to OSHPD.

Length of Stay (LOS). The duration of an inpatient's stay in a hospital, which is calculated by subtracting the date of admission from the date of discharge. A patient admitted and discharged on the same day has a calculated LOS of one day.

Licensed Beds. The maximum number of beds a hospital or health facility is licensed to operate for inpatient medical services.

Licensee. An entity that has been issued a license to operate a hospital, as defined by Subdivision (c) of Section 128700 of the California Health and Safety Code.

Major Diagnostic Category (MDC). Groupings of patients into major clinical categories based on organ systems and disease etiology, as established and maintained by HCFA.

Managed Care. A healthcare plan (e.g., HMO, PPO) that attempts to manage or control spending and costs by closely monitoring how doctors treat patients. To keep costs down, these plans may limit referrals to specialists and require pre-authorization for services.

Medicaid. A federally aided, state-operated and administered program that provides medical benefits for certain low income persons in need of health and medical care, authorized by Title XIX of the Social Security Act.

Medi-Cal. A federally-aided, state operated and administered program which provides medical benefits for certain low-income persons. This is California's version of the federal Medicaid program.

Medicare. A nationwide health insurance program for persons aged 65 and older, for persons who have been eligible for social security disability payments for more than two years, and for certain workers and their dependents who need kidney transplantation or dialysis, authorized by Title XVIII of the Social Security Act.

Mental Health Rehabilitation Centers (MHRC). Licensed by the California Department of Mental Health (a pilot program). The California Department of Mental Health equates this designation to the California Department of Social Services designation of residential care facilities.

Newborn. An infant, born alive in this hospital.

GLOSSARY OF TERMS AND ABBREVIATIONS

Observation. The following description for observation of patient to determine need for inpatient admission is obtained from the Medicare and Medicaid Guide, Part B Coverage, Paragraph 3120.55:

> "Observation of patient to determine need for inpatient admission.—In summary, HCFA guidelines provide the following description of out-patient observation services:
>
> > Observation services are as those services furnished on a hospital's premises and include the use of a bed and periodic monitoring by a hospital's nursing or other staff. Such services may be reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient…"

Outpatient. A individual who receives healthcare services in a hospital or other healthcare facility without being admitted as an inpatient.

Preferred Provider Organization (PPO). A previously negotiated arrangement between purchasers and providers to furnish specified health services to a group of employees/patients. An insurance company or employer negotiates discounted fees with networks of healthcare providers in return for guaranteeing a certain volume of patients.

Prepaid Health Plan (PHP). Generally, a contract between an insurer and a subscriber or group of subscribers whereby the PHP provides a specified set of health benefits in return for a periodic premium.

Principal Diagnostic Group (PDG). The major group of diseases, disorders, and conditions as listed in, and roughly corresponding to, the chapters of the ICD-9-CM.

Professional Component. The portion of the charges billed by the hospital for patient care that is attributable to physicians' services.

Psychiatric Care. Care rendered in an acute psychiatric hospital, in a PHF, or in an acute psychiatric bed in a GACH. A classification of hospital licensure and hospital beds, as defined by Sections 1250, 1250.1, and 1250.2 of the California Health and Safety Code.

Psychiatric Health Facility (PHF). Defined by Section 1250.2 of the California Health and Safety Code. PHF's contain beds classified as acute psychiatric beds and deliver psychiatric care.

Record. The set of elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the California Health and Safety Code.

Record Linkage Number (RLN). The encrypted Social Security number. A nine-digit alphanumeric identifier that allows for accurate linkage of a patient's multiple discharges over a period of time and across different hospitals.

Report. The collection of all discharge data records submitted by a hospital for a semiannual reporting period or for a shorter period pursuant to Subsection (b) of Section 97211 of the California Code of Regulations.

GLOSSARY OF TERMS AND ABBREVIATIONS

Residential Care. 24-hour care in facilities licensed by the Department of Social Services that provide for the maintenance and subsistence of persons with long-term mental or other disabilities. Services provided include personal assistance, personal hygiene, monitoring of prescribed medication, supervision, and provision of social and recreational activities. Medication and nursing are not included.

Skilled Nursing Facility (SNF). A health facility that provides skilled nursing care and supportive care to patients whose primary need is for skilled nursing care on an extended basis, as defined by Section 1250 of the California Health and Safety Code.

Skilled Nursing/Intermediate Care (SN/IC). Nursing and personal care services provided over an extended period to persons who require convalescence, custodial care, and/or who are chronically ill, aged, or disabled. These type of care beds may be found as distinct parts in GACHs and in APHs.

Social Security Number (SSN). The number assigned by the U.S. Social Security Administration, to maintain permanent and accurate earnings records of persons whose employment is covered by the Social Security program.

Standard Nomenclature of Diseases and Operations (SNODO). A nomenclature system in which each disease is classified to both anatomical location and etiology.

Sub-Acute Care. A level of reimbursement established within the Medi-Cal program. Adult and pediatric sub-acute level of care refers to very intensive, licensed, skilled nursing care provided in Distinct-Part/Nursing Facilities Level B (DP/NF-B) in acute care hospitals or in Free-standing Nursing Facilities Level B (FS/NF-B) to patients who have a fragile medical condition. Beds designated for either adult or pediatric sub-acute care cannot be used for swing beds. Sub-acute care may also be provided in acute care beds.

Swing Beds. Hospital-based acute care beds that may be used flexibly to serve as skilled nursing care beds.

Title V. Maternal and Child Health. Defined in Title V of the Federal Medicare Act (PL 89-97). Applies only to females aged 60 or younger or males aged 21 or younger.

Transitional Care. A level of reimbursement established within the Medi-Cal program. A level of care for eligible recipients in qualifying health facilities who require short-term medically complex or intensive rehabilitative services, or both.

Prior authorization is required before transitional care may be rendered. Transitional care may be rendered by:

- General acute care hospitals
- Distinct-Part Nursing Facility Level B of general acute care hospitals (DP/NF-B)
- Free-standing Nursing Facility Level B (FS/NF-B)

TRICARE. Current name for the Civilian Health and Medical Program for the Uniformed Services, formerly CHAMPUS. "TRI" represents the three primary branches of the armed forces, Army, Navy, and Air Force.

Type of Care (TOC). One of the following, as defined by Subsection (i) of Section 97212 of the California Code of Regulations:

- Skilled nursing/intermediate care
- Physical rehabilitation care
- Psychiatric care
- Chemical dependency recovery care
- Acute care

Uniform Hospital Discharge Data Set (UHDDS). The hospital discharge data set periodically issued by the U.S. Department of Health and Human Services.

V-codes. Supplementary Classification of ICD-9-CM, containing Factors Influencing Health Status and Contact with Health Services.

ZIP Code. A code applied to geographic areas by the U.S. Postal Service for efficiency in delivering mail. Thus, a ZIP Code may cut across civil boundaries (such as counties), and are likely to observe natural geographic features, such as rivers and mountain ranges.

APPENDIX B

PENALTIES
AND
APPEALS

PENALTIES AND APPEALS

California Health and Safety Code, Division 107 Statewide Health Planning and Development, Part 5 Health Data, Chapter 1 Health Facility Data.

Section 128770. Penalties; disposition.

See Appendix D.

TITLE 22, California Code of Regulations, Division 7, Chapter 10. Health Facility Data, Article 3. Required Reporting

Section 97045. Failure to File Required Reports.

Any health facility which does not file with the Office any report completed as required by this Article or by Article 8 is liable for a civil penalty of one hundred dollars ($100) a day to be assessed and recovered in a civil action brought in the name of the people of the State of California by the Office for each day the filing of such report with the Office is delayed, considering all approved extensions of the due date as provided in Section 97051 or in Section 97214. Assessed penalties may be appealed pursuant to Section 97052. Within fifteen days after the date the reports are due, the Office shall notify the health facility of reports not yet received, the amount of liability, and potential future liability for failure to file said reports when due.

TITLE 22, California Code of Regulations, Division 7, Chapter 10. Health Facility Data, Article 4. Modification, Extension, and Appeal Processes

Section 97050. Request for Modifications to Approved Accounting and Reporting Systems.

See Section 97240 of the California Code of Regulations (Appendix E).

Section 97051. Requests for Extension Time to File Required Reports.

See Section 97241 of the California Code of Regulations (Appendix E).

Section 97052. Appeal Procedure.

(a) Any health facility affected by any determination made under the Act by the Office may appeal the decision. This appeal shall be filed with the Office within 15 business days after the date the notice of the decision is received by the health facility and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing on an appeal shall, at the discretion of the Director, be held before any one of the following:

(1) An employee of the Office appointed by the Director to act as hearing officer.

(2) A hearing officer employed by the Office of Administrative Hearings.

(3) A committee of the Commission chosen by the chairperson for this purpose.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128775, Health and Safety Code.

Section 97053. Conduct of Hearing.

(a) The hearing, when conducted by an employee of the Office appointed by the Director to serve as hearing officer or by a committee of the Commission, shall not be conducted according to technical rules relating to evidence and witnesses. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.

(b) When the hearing is conducted by an employee of the Office or by a committee of the Commission, the hearing shall be recorded by a tape recording, unless the appellant agrees to provide a certified shorthand reporter at the appellant's expense. If the appellant provides a certified shorthand reporter, the original of the transcript shall be provided directly to the Office.

(c) A copy of the tape recording or of the transcript, if made, shall be available to any person so requesting who has deposited with the Office an amount of money which the Director has determined to be sufficient to cover the costs of the copy of the tape recording or transcript.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128775, Health and Safety Code.

Section 97054. Decision on Appeal.

(a) The employee, hearing officer, or committee shall prepare a recommended decision which includes findings of fact and conclusions of law.

(b) This proposed decision shall be presented to the Office for its consideration.

(c) The Office may adopt the proposed decision, or reject it and decide the matter as described in paragraph 1 below.

(1) If the Office does not adopt the proposed decision as presented, it will furnish a Notice of Rejection of Proposed Decision along with a copy of the proposed decision to appellant and, if applicable, appellant's authorized representative. The Office will provide appellant the opportunity to present written arguments to the Office. The decision of the Office will be based on the record,

including the hearing record, and such additional information as is provided by the appellant.

(d) The decision of the Office shall be in writing. It shall be made within 60 calendar days after the conclusion of the hearing and shall be final.

Authority: Section 128810, Health and Safety Code
Reference: Section 128775, Health and Safety Code

DISCUSSION:

See attached Appeals Process for Civil Penalties.

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HEALTHCARE INFORMATION DIVISION
PATIENT DISCHARGE DATA SECTION
818 K Street, Room 100
Sacramento, California 95814
(916) 323-7679 FAX (916) 327-1262

MAILING NOTICE

If you choose to submit an appeal, complete forms on pages 7 and 8 (Appendix B) and return to:

Office of Statewide Health Planning and Development
Patient Discharge Data Section
818 K Street, Room 100
Sacramento CA 95814

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HEALTHCARE INFORMATION DIVISION
PATIENT DISCHARGE DATA SECTION
818 K Street, Room 100
Sacramento, California 95814
(916) 323-7679 FAX (916) 327-1262

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

APPEALS PROCESS FOR CIVIL PENALTIES ASSESSED PURSUANT TO THE HEALTH DATA AND ADVISORY COUNCIL CONSOLIDATION ACT

RIGHT TO APPEAL

Any health facility that has been assessed a penalty pursuant to Health and Safety Code Section 128770 may petition the Office for review of the penalty assessment. An appeal must be filed within fifteen (15) business days of the day the facility receives notification of the penalty assessment. The right to appeal is forfeited if an appeal is not either received by the Office or postmarked within fifteen (15) business days of notification of any action or decision. If an appeal is submitted, the facility is entitled to a formal administrative hearing within sixty (60) days.

HOW TO APPEAL

The Office provides a form that may be used to file an appeal. Use of this form is not mandatory, but any appeal must be in writing and must include all necessary information. An appeal must be signed by the licensee or administrator, unless they choose someone else to represent the hospital.

If the licensee or administrator chooses someone else to represent the facility in its appeal, the Office must be notified in writing of that delegation of authority. (A form for this purpose accompanies the appeal form.) The licensee or administrator should be aware that they will be bound by the statements and actions of an authorized representative.

INFORMAL PROCEDURE

For the convenience of health facilities filing appeals, the Office has established an informal appeal process. The informal procedure does not require the facility to actually attend a hearing. Review of the appeal is based on written materials submitted by the facility as well as the Office's records. If a facility elects to use the informal procedure, it still has the right to request a formal hearing if it is not satisfied with the informal decision. However, in order for a facility to take advantage of the informal procedure, it must waive its right to have a formal hearing held within sixty (60) days.

The informal procedure works as follows:

1. The facility files an appeal, requests an informal review, states the grounds for the appeal and agrees to waive the sixty (60) day limit.

2. The Chief Counsel for the Office reviews the appeal, makes a decision and notifies the facility.

3. The facility has fifteen (15) business days from the date it receives the written decision in the mail to either accept it or to reject it and request a formal hearing.

4. If a formal hearing is requested, one is scheduled.

FORMAL HEARING

Appeals are heard by the three-member Appeals Committee of the California Health Policy and Data Advisory Commission. Formal hearings are conducted substantially in conformity with the California Administrative Procedure Act. The facility may be represented by an attorney, but this is not required. The hearing will be tape recorded. The facility may, at its expense, supply a court reporter.

The Appeals Committee will consider any relevant evidence offered if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The Appeals Committee will prepare a recommended decision, including findings of fact and conclusions of law, and present it to the Office. The decision of the Office will be made in writing within sixty (60) days of the conclusion of the hearing. It will be the final administrative decision.

References: Health and Safety Code Sections 128770 and 128775 and Title 22, California Code of Regulations, Section 97052, 97053 and 97054.

Revised 7/1/97

PETITION TO THE
OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Facility Name _____

Address _____

Telephone _____ OSHPD Identification No. _____

Authorized Representative (if any) _____

Address _____
Street City State Zip Code

Telephone _____

Petitioner appeals the decision of the Office of Statewide Health Planning and Development dated _____.

Check one

[ ] Petitioner wishes to use the Office's informal procedure.
We waive our right to a formal hearing within 60 days.

[ ] Petitioner does not wish to use the informal procedure and requests a formal hearing within 60 days.

This appeal is based on the following grounds: (Attach additional pages as necessary.)

Name* _____ Title _____
Please Print Please Print
Signature _____ Date _____

Attachment(s) [ ] Yes [ ] No

*Representatives other than the facility administrator or licensee must have written authorization from the facility administrator or licensee, a copy of which must be attached to this form.

AUTHORIZATION TO REPRESENT

FACILITY IN APPEAL

_____ is hereby authorized to represent
(Name of Authorized Representative)

_____
Name of Facility

before the Office of Statewide Health Planning and Development. This authorization extends to all communications between our representative and the Office, its staff, or the Appeals Committee of the California Health Policy and Data Advisory Commission, concerning this appeal. This authorization may be terminated at any time upon written notice to the Office.

_____ _____
Facility Administrator or Licensee Name Title

_____ _____
Signature Date

APPENDIX C

STANDARD FORMAT AND SPECIFICATIONS FOR MAGNETIC TAPE, 3½ AND 5¼ DISKETTES, OR CD-ROM

DATA ELEMENT SPECIFICATIONS
MAGNETIC TAPE, DISKETTE, OR CD-ROM

PATIENT DISCHARGE DATA SECTION
STANDARD FORMAT AND SPECIFICATIONS FOR
MAGNETIC TAPE, 3½ AND 5¼ DISKETTES, OR CD-ROM

The format and specifications are for discharge data to be submitted on magnetic tape, 3½" and 5¼" diskettes, or CD-ROM. The record format and additional requirements are described on Pages 3 and 4 for magnetic tape and Pages 5 and 6 for diskettes and CD-ROM. The specifications for record positions, data lengths, data types, and coding structures for each of the required data elements are described on Pages 7 through 24.

A test data file MUST be sent to the Office of Statewide Health Planning and Development (OSHPD) for review and acceptance before authorization for the hospital's reporting system can be granted, regardless of whether it is a new system or a change in the existing system, as specified in Subsection (a) of Section 97210 and Section 97125 of the California Code of Regulations (CCR).

Each hospital is required, as specified by Section 97215 of the CCR, to submit a test data file at least 60 days before the next reporting period due date. The 60 days allow sufficient time for the testing process and avoids the possibility of a penalty situation because of late filing of the discharge data report. Each hospital or its designated agent is required to demonstrate compliance with the appropriate format and specifications BEFORE OSHPD will accept its discharge data file.

To "pass" the testing process, the test data must first meet the format and specifications so that OSHPD can successfully process the discharge data, and the test data file must contain at least one record in each of the required data element categories.

If the test data file fails to meet the format and specifications and/or does not reflect data in each of the required data element categories, an acceptable revised test data file is required.

To submit your test data file, you must complete Page 2 for all computer media, as well as Page 3 for computer tape only, of the Standard Format and Specifications package and an Individual Hospital or Agent's Transmittal Form-OSHPD 1370.1 or 1370.2. Forward the appropriate document with your test data file to the address below:

Office of Statewide Health Planning and Development
Patient Discharge Data Section
818 K Street, Room 100
Sacramento, California 95814

DATA ELEMENT SPECIFICATIONS
MAGNETIC TAPE, DISKETTE, OR CD-ROM

Complete the following information and return with the test data file:

HOSPITAL: _____

HOSPITAL IDENTIFICATION NUMBER: ____ ____ ____ ____ ____ ____

CONTACT PERSON: _____

TITLE: _____

ADDRESS: _____

_____

_____

TELEPHONE NUMBER: _____

NUMBER OF RECORDS IN TEST DATA FILE: _____

Was the software for your computer reporting system developed in-house:

YES [ ] NO [ ]

If you respond No to the above question, please complete the following:

Indicate the company that provided the software for your computer reporting system:

_____

Indicate the first semiannual reporting period for which you intend to submit discharge data using your reporting system after the system has been tested and approved:

January 1 – June 30 ☐

_____
Year

July 1 – December 31 ☐

FOR USE WITH DISCHARGES ON AND AFTER 1/1/99

Revised March 1998

DATA ELEMENT SPECIFICATIONS
MAGNETIC TAPE, DISKETTE, OR CD-ROM

STANDARD RECORD FORMAT
MAGNETIC TAPE

The standard record format options for reporting discharge data on magnetic tape are described below. An asterisk (*) denotes the preferred format. Please check the format you choose to prepare your tape:

Recording Density: [ ] 6250 BPI, 9-Track

[ ] 1600 BPI, 9-Track

[ ] IBM 3480 compatible cartridge tape*

NOTE: This DOES NOT include the ½inch "DC type" cartridges.

Recording Mode: [ ] EBCDIC*

[ ] ASCII

Labels: [ ] IBM Standard*

[ ] Unlabeled

Record Format: Fixed, 520 bytes

Block Size: [ ] 5,200 bytes (Blocked 10 records)*

[ ] Other (maximum 32,760 bytes or 63 records per block). Specify number of records per block:

_____

FOR USE WITH DISCHARGES ON AND AFTER 1/1/99

Revised March 1998

DATA ELEMENT SPECIFICATIONS
MAGNETIC TAPE, DISKETTE, OR CD-ROM

STANDARD RECORD FORMAT
MAGNETIC TAPE

ADDITIONAL REQUIREMENTS

- NO packed or binary data**.**
- The tape format requires a fixed-block only.
- All unused alphanumeric and alphabetic fields must be spaced-filled.
- All alpha fields must be in UPPER CASE.
- All unused numeric fields must be zero-filled.
- Each tape should consist of a single file only. Multiple tapes are not allowed. The single data file may contain multiple facilities; however, tape marks between the facilities are not permitted.
- If the single data file exceeds the capacity of the tape, a second tape is acceptable to complete the data file. Each tape must be labeled indicating the processing order.
- The reporting period must not be split into smaller periods and written as separate data files on one or more tapes. Exceptions are allowed for changes in licensee. The effective date of the change in licensee shall constitute the start of the reporting period for the new licensee, and this reporting period shall end on June 30 or December 31, whichever occurs first. The final day of the reporting period for the previous licensee shall be the last day their licensure was effective, and the due date for the report shall be six months after the final day of this reporting period.
- The entire tape must contain either all EBCDIC or all ASCII characters. Unused fields must be properly initialized. The normal recording mode of your computer should be used in writing the tapes to avoid the mixing of recording modes.
- The 6-digit hospital identification number indicated on the transmittal form must be exactly as it appears on the tape in positions 2 through 7.

DATA ELEMENT SPECIFICATIONS
MAGNETIC TAPE, DISKETTE, OR CD-ROM

STANDARD RECORD FORMAT
3½ DISKETTE

The following format is to be used for submitting the required discharge data on 3½ diskette. Deviation from the format will not be accepted.

1. 3½diskette (either 720KB, 1.44MB or 2.88 MB).
2. DOS format.
3. One reporting facility and time period (one file) per diskette.
4. Standard ASCII character coding.
5. Readable by an IBM compatible PC diskette drive
6. Record length 520 characters followed by a carriage return and line feed.

STANDARD RECORD FORMAT
5¼" DISKETTE

The following format is to be used for submitting the required discharge data on 5¼" diskette. Deviation from the format will not be accepted.

1. 5¼" diskette (1.2MB).
2. DOS format.
3. One reporting facility and time period (one file) per diskette.
4. Standard ASCII character coding.
5. Readable by an IBM compatible PC diskette drive.
6. Record length 520 characters followed by a carriage return and line feed.

STANDARD RECORD FORMAT
CD-ROM

The following format is to be used for submitting the required discharge data on CD-ROM. Deviation from the format will not be accepted

1. ISO 9660 CD-ROM IBM compatible.
2. DOS format.
3. One reporting facility and time period (one file) per diskette.
4. Standard ASCII character coding.
5. Readable by an IBM compatible PC CD-ROM drive.
6. Record length 520 characters followed by a carriage return and line feed.

FOR USE WITH DISCHARGES ON AND AFTER 1/1/99

Revised March 1998

DATA ELEMENT SPECIFICATIONS
MAGNETIC TAPE, DISKETTE, OR CD-ROM

CREATING THE 3½ AND 5¼" DISKETTES OR CD-ROM FILE

The preferred method of creating the diskette or CD-ROM file is to COPY the file from your system's drive directly to the diskette or CD-ROM. There will be a problem if the file size is greater than the diskette or CD-ROM. This most likely will occur on smaller diskettes but could occur on any diskette. If this situation occurs, the only acceptable way to transfer the data to diskette or CD-ROM is by breaking the data into multiple files that will fit on a single diskette or CD-ROM. Due to the wide variety of DOS operating systems and the many different versions, there is substantial risk in using the BACKUP/RESTORE functions. The risk is in the incompatibility of the various versions of DOS in BACKUP and RESTORE. Therefore, you must inform us of the total number of records and clearly label the diskettes or CD-ROMs. OSHPD will use the diskettes or CD-ROM to build the larger file on our hard disk and then resume normal processing of your data.

Prior to sending a diskette or CD-ROM to OSHPD, it is advisable to do a DIR on the diskette or CD-ROM and verify that it contains the file.

STANDARD RECORD FORMAT
3½ AND 5¼" DISKETTES OR CD-ROM
ADDITIONAL REQUIREMENTS

- No packed or binary data.
- All unused alphanumeric and alphabetic fields must be space-filled.
- All alpha fields must be in UPPER CASE.
- All unused numeric fields must be zero-filled.
- The 6-digit hospital identification number indicated on the transmittal form must be exactly as it appears on the diskette or CD-ROM in positions 2 through 7.
- One reporting hospital and one reporting period (one data file) per diskette or CD-ROM.

DATA ELEMENT SPECIFICATIONS
MAGNETIC TAPE, DISKETTE, OR CD-ROM

STANDARD RECORD FORMAT
MAGNETIC TAPE, DISKETTE, OR CD-ROM

Description	From	Through	Format[1]
Patient's Type of Care	1	1	N(1)
Hospital Identification Number	2	7	N(6)
Date of Birth	8	15	N(8)
Sex	16	16	N(1)
Race			
Ethnicity	17	17	N(1)
Race	18	18	N(1)
ZIP Code	19	23	X(5)
Admission Date	24	31	N(8)
Source of Admission			
Site	32	32	N(1)
Licensure of Site	33	33	N(1)
Route of Admission	34	34	N(1)
Type of Admission	35	35	N(1)
Discharge Date	36	43	N(8)
Principal Diagnosis	44	48	X(5)
Principal Diagnosis Present at Admission	49	49	A(1)
Other Diagnoses	50	-----	X(5)[2]
Other Diagnoses Present at Admission	-----	193	A(1)[2]
Principal Procedure Code	194	197	X(4)
Principal Procedure Date	198	205	N(8)
Other Procedure Codes	206	-----	X(4)[3]
Other Procedures Dates	-----	445	N(8)[3]
Principal E-Code	446	450	X(5)
Other E-Codes	451	470	X(5)[4]
Patient's Social Security Number	471	479	N(9)
Disposition of Patient	480	481	N(2)
Total Charges	482	488	N(7)
Abstract Record Number	489	500	X(12)
DNR Order	501	501	A(1)
Unused	502	502	X(1)
Expected Source of Payment			
Payer Category	503	504	N(2)
Type of Coverage	505	505	N(1)
Plan Code Number	506	509	N(4)
Unused	510	520	X(11)

Footnotes are on Page 8

FOR USE WITH DISCHARGES ON AND AFTER 1/1/99

Revised March 1998

FOOTNOTES

[1]Format indicates data type and length (in parentheses). Data type is defined as:

A = Alpha
N = Numeric
X = Alphanumeric

[2]This variable and its format occurs 24 times. Fill from the left-most position and **DO NOT** skip fields. Each other diagnosis and its condition present at admission is paired. The first pair is in positions 50-55, the second pair in 56-61, the third pair in 62-67, and so on consecutively through 24 pairs.

[3]This variable and its format occurs 20 times. Fill from the left-most position and **DO NOT** skip fields. Each other procedure and its date is paired. The first pair is in positions 206-217, the second pair in 218-229, the third pair in 230-241, and so on consecutively though 20 pairs.

[4]This variable and its format occurs 4 times. Fill from the left-most position and **DO NOT** skip fields.

PATIENT'S TYPE OF CARE

Record Position:	1
Data Length:	1
Data Type:	Numeric
Codes:	1 = Acute Care 3 = Skilled Nursing/Intermediate Care 4 = Psychiatric Care 5 = Chemical Dependency Recovery Care 6 = Physical Rehabilitation Care

HOSPITAL IDENTIFICATION NUMBER

Record Positions:	2 through 7
Data Length:	6
Data Type:	Numeric
Codes:	Hospital Identification Number (the unique facility number assigned by OSHPD). This field is required for each record.

DATE OF BIRTH

Record Positions:	8 through 15
Data Length:	8
Data Type:	Numeric
Codes:	99 99 9999 Month Day Year
Special Instructions:	Single-digit months and days must include a preceding zero.

SEX

Record Position:	16
Data Length:	1
Data Type:	Numeric
Codes:	1 = Male
	2 = Female
	3 = Other
	4 = Unknown

RACE

Ethnicity

Record Position:	17
Data Length:	1
Data Type:	Numeric
Codes:	1 = Hispanic
	2 = Non-Hispanic
	3 = Unknown

RACE

Record Position:	18
Data Length:	1
Data Type:	Numeric
Codes:	1 = White
	2 = Black
	3 = Native American/Eskimo/Aleut
	4 = Asian/Pacific Islander
	5 = Other
	6 = Unknown

ZIP CODE

Record Positions:	19 through 23
Data Length:	5
Data Type:	Alphanumeric
Codes:	5 digit ZIP Code XXXXX = Unknown YYYYY = Foreign ZZZZZ = Homeless
Special Instructions:	XXXXX, YYYYY, and ZZZZZ must be reported in UPPER CASE.

ADMISSION DATE

Record Positions:	24 through 31
Data Length:	8
Data Type:	Numeric
Codes:	99 99 9999 Month Day Year
Special Instructions:	Single-digit months and days must include a preceding zero.

SOURCE OF ADMISSION

Site

Record Position:	32
Data Length:	1
Data Type:	Numeric
Codes:	1 = Home
	2 = Residential Care Facility
	3 = Ambulatory Surgery
	4 = Skilled Nursing/Intermediate Care
	5 = Acute (Inpatient) Hospital Care
	6 = Other (Inpatient) Hospital Care
	7 = Newborn
	8 = Prison/Jail
	9 = Other

Licensure Of Site

Record Position:	33
Data Length:	1
Data Type:	Numeric
Codes:	1 = This Hospital
	2 = Another Hospital
	3 = Not a Hospital

Route Of Admission

Record Position:	34
Data Length:	1
Data Type:	Numeric
Codes:	1 = Your Emergency Room
	2 = Not Your Emergency Room

TYPE OF ADMISSION

Record Position:	35
Data Length:	1
Data Type:	Numeric
Codes:	1 = Scheduled 2 = Unscheduled 3 = Infant, under 24 hrs. old 4 = Unknown

DISCHARGE DATE

Record Positions:	36 through 43
Data Length:	8
Data Type:	Numeric
Codes:	99 99 9999 Month Day Year
Special Instructions:	Single-digit months and days must include a preceding zero.

PRINCIPAL DIAGNOSIS

Record Positions:	44 through 48
Data Length:	5
Data Type:	Alphanumeric
Codes:	International Classification of Diseases, 9th Revision, Clinical Modification
Special Instructions:	The ICD-9-CM code must be left-justified and space-filled. The default value is all spaces.

PRINCIPAL DIAGNOSIS CONDITION PRESENT AT ADMISSION

Record Position:	49
Data Length:	1
Data Type:	Alpha
Codes:	Y = Yes N = No U = Uncertain
Special Instruction:	Y, N, and U must be reported in UPPER CASE.

OTHER DIAGNOSES

Record Positions:	50 through 54, 56-60, 62-66, etc. consecutively through 24 codes ending in position 192
Data Length:	5
Data Type:	Alphanumeric
Codes:	International Classification of Diseases, 9th Revision, Clinical Modification
Special Instructions:	The ICD-9CM code must be left-justified and space-filled. Fill from the left-most position and **DO NOT** skip fields The default value is all spaces. Do not include E-codes.

OTHER DIAGNOSES CONDITIONS PRESENT AT ADMISSION

Record Positions:	55, 61, 67, etc. consecutively through 24 codes ending in position 193
Data Length:	1
Data Type:	Alpha
Codes:	Y = Yes N = No U = Uncertain
Special Instructions:	Y, N, and U must be reported in UPPER CASE.

PRINCIPAL PROCEDURE AND DATE

Principal Procedure Code

Record Positions:	194 through 197
Data Length:	4
Data Type:	Alphanumeric
Codes:	International Classification of Diseases, 9th Revision, Clinical Modification
Special Instructions:	The procedure code must be left-justified and space-filled. The default value is all spaces.

Principal Procedure Date

Record Positions:	198 through 205
Data Length:	8
Data Type:	Numeric
Codes:	99 99 9999 Month Day Year
Special Instructions:	Single-digit months and days must include a preceding zero. When there is no principal procedure, the default value is all zeros.

OTHER PROCEDURES AND DATES

OTHER PROCEDURES CODES

Record Positions:	206 through 209, 218-221, 230-233, etc. consecutively through 20 codes ending in position 437
Data Length:	4
Data Type:	Alphanumeric
Codes:	International Classification of Diseases, 9th Revision, Clinical Modification
Special Instructions:	Other procedures codes must be left-justified and space-filled. Fill from the left-most position and **DO NOT** skip fields. The default value is all spaces.

OTHER PROCEDURES DATES

Record Positions:	210 through 217, 222-229, 234-241, etc. consecutively through 20 codes ending in position 445
Data Length:	8
Data Type:	Numeric
Codes:	99 99 9999 Month Day Year
Special Instructions:	Single-digit months and days must include a preceding zero. When there are no other procedures codes, the default value is zeros.

PRINCIPAL E-CODE

Record Positions:	446 through 450
Data Length:	5
Data Type:	Alphanumeric
Codes:	International Classification of Diseases, 9th Revision, Clinical Modification
Special Instructions	The ICD-9-CM code must be left-justified and space-filled. The default value is all spaces.

OTHER E-CODES

Record Positions:	451 through 455, 456-460, 461-465, and 466-470 (maximum of 4 E-Codes)
Data Length:	5
Data Type:	Alphanumeric
Codes:	International Classification of Diseases, 9th Revision, Clinical Modification
Special Instructions:	The ICD-9-CM code must be left-justified and space-filled. The default value is all spaces.

PATIENT'S SOCIAL SECURITY NUMBER

Record Positions:	471 through 479
Data Length:	9
Data Type:	Numeric
Codes:	Enter the full 9-digit SSN including zeros. **DO NOT** use hyphens. Enter 000000001 if the SSN is not recorded in the patient's medical record.

DISPOSITION OF PATIENT

Record Positions:	480 through 481
Data Length:	2
Data Type:	Numeric
Codes:	01 = Routine Discharge 02 = Acute Care Within This Hospital 03 = Other Type of Hospital Care Within This Hospital 04 = Skilled Nursing/Intermediate Care Within This Hospital 05 = Acute Care at Another Hospital 06 = Other Type of Hospital Care at Another Hospital (Not Skilled Nursing/Intermediate Care) 07 = Skilled Nursing/Intermediate Care Elsewhere 08 = Residential Care Facility 09 = Prison/Jail 10 = Against Medical Advice 11 = Died 12 = Home Health Service 13 = Other
Special Instructions:	Single digit values must include a preceding zero.

TOTAL CHARGES

Record Positions:	482 through 488
Data Length:	7
Data Type:	Numeric
Codes:	Whole dollars only—no cents. Code 9999999 for Total Charges exceeding 7 positions.
Special Instructions:	Total Charges must be right-justified, zero-filled, and unsigned. The default value is all zeros.

ABSTRACT RECORD NUMBER (OPTIONAL)

Record Positions:	489 through 500
Data Length:	12
Data Type:	Alphanumeric
Code:	Optional medical record number or any patient identification number assigned by the hospital.
Special Instructions:	The Abstract Record Number must be left-justified and space-filled. If not reported, the default value is all spaces.

DO NOT RESUSCITATE (DNR) ORDER

Record Position:	501
Data Length:	1
Data Type:	Alpha
Codes:	Y = Yes N = No
Special Instructions:	Y and N must be reported in UPPER CASE.

UNUSED

Record Position:	502
Data Length:	1
Data Type:	Alphanumeric
Codes:	Space

EXPECTED SOURCE OF PAYMENT

Payer Category

Record Positions:	503 through 504
Data Length:	2
Data Type:	Numeric
Codes:	01 = Medicare 02 = Medi-Cal 03 = Private Coverage 04 = Workers' Compensation 05 = County Indigent Programs 06 = Other Government 07 = Other Indigent 08 = Self Pay 09 = Other Payer
Special Instructions:	Single-digit codes must included a preceding zero.

EXPECTED SOURCE OF PAYMENT, CONTINUED

Type of Coverage

Record Position:	505
Data Length:	1
Data Type:	Numeric
Codes:	1 = Managed Care – Knox-Keene or Medi-Cal County Organized Health System 2 = Managed Care – Other 3 = Traditional Coverage
Special Instructions:	Type of Coverage MUST be reported if Payer Category 01, 02, 03, 04, 05, or 06 is reported. If Payer Category 07, 08, or 09 is reported, the default value is zero.

Plan Code Number

Record Positions:	506 through 509
Data Length:	4
Data Type:	Numeric
Codes:	Refer to attached Tables of the Plan Code Names and Plan Code Numbers, Pages 22 through 24.
Special Instructions:	The Plan Code Number must be right-justified and zero-filled. The Plan Code Number MUST be reported if Type of Coverage 1 is reported. If Type of Coverage 2 or 3 is reported, the default value is zero.

Unused

Record Positions:	510 through 520
Data Length:	11
Data Type:	Alphanumeric
Codes:	Spaces

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers
For use with discharges occurring in 1999

Plan Code Names	Plan Code Numbers
Aetna Health Plans of California, Inc.	0176
Alameda Alliance for Health	0328
American Family Care	0322
Blue Cross of California	0303
Blue Shield of California	0043
BPS HMO	0314
Brown and Toland Medical Group	0352
Calaveras Provider Network	0365
Care 1st Health Plan	0326
Careamerica-Southern California, Inc.	0234
Chinese Community Health Plan	0278
Cigna Healthcare of California, Inc.	0152
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Contra Costa Health Plan	0054
Concentrated Care, Inc.	0360
Foundation Health, a California Health Plan	0109
Great American Health Plan	0327
Greater Pacific HMO Inc	0317
HAI	0292
Healthmax America	0277
Health Net	0300
Health Plan of America (HPA)	0126
Health Plan of the Redwoods	0159
Heritage Provider Network, Inc.	0357
Inland Empire Health Plan	0346
Inter Valley Health Plan	0151
Kaiser Foundation Added Choice Health Plan	0289
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems Inc	0335
Key Health Plan of California	0343
Lifeguard, Inc.	0142
LA Care Health Plan	0355
Managed Health Network	0196

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers, Continued
For use with discharges occurring in 1999

Maxicare	0002
MCC Behavioral Care of California, Inc.	0298
MedPartners Provider Network, Inc.	0345
Metrahealthcare Plan	0266
Merit Behavioral Care of California, Inc.	0288
Monarch Plan Inc.	0270
National Health Plans	0222
National HMO	0222
Occupational Health Services (OHS)	0235
Omni Healthcare, Inc.	0238
One Health Plan of California Inc.	0325
Pacificare Behavioral Health of California Inc.	0301
Pacificare of California	0126
Priorityplus of California	0237
Prucare Plus	0296
Qualmed Plans for Health	0300
Regents of the University of California	0354
San Francisco Health Plan	0349
Santa Clara County Family Health Plan	0351
Secure Horizons	0126
Sharp Health Plan	0310
Smartcare Health Plan	0212
The Health Plan of San Joaquin	0338
Tower Health Service	0324
UHC Healthcare	0266
UHP Healthcare	0008
Universal Care	0209
Valley Health Plan	0236
Value Behavioral Health of California, Inc.	0293
Ventura County Healthcare Plan	0344
Vista Behavioral Health Plan	0102
Western Health Advantage	0348
Other	8000

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers
For use with discharges occurring in 1999

Name of Medi-Cal County Organized Health System	Plan Code Numbers
Cal Optima (Orange County)	9030
Health Plan of San Mateo (San Mateo County)	9041
Santa Barbara Health Authority(Santa Barbara County)	9042
Santa Cruz County Health Options (Santa Cruz County)	9044
Solano Partnership Health Plan (Solano County)	9048

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers:
For use with discharges occurring in 2000

Plan Code Names	Plan Code Numbers
Aetna Health Plans of California, Inc.	0176
Alameda Alliance for Health	0328
Blue Cross of California	0303
Blue Shield of California	0043
BPS HMO	0314
Calaveras Provider Network	0365
Care 1st Health Plan	0326
Cedars-Sinai Provider Plan, LLC	0366
Chinese Community Health Plan	0278
Cigna Healthcare of California, Inc.	0152
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Concentrated Care, Inc.	0360
Contra Costa Health Plan	0054
FPA Medical Management of California, Inc	0350
Great American Health Plan	0327
Greater Pacific HMO Inc	0317
HAI, Hai-Ca	0292
Healthmax America	0277
Health Net	0300
Health Plan of America (HPA)	0126
Health Plan of the Redwoods	0159
Health Plan of San Mateo Healthy Families, not COHS	0358
Heritage Provider Network, Inc.	0357
Holman Professional Counseling Centers	0231
Inland Empire Health Plan	0346
Inter Valley Health Plan	0151
Kaiser Foundation Added Choice Health Plan	0289
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems Inc	0335
Key Health Plan of California	0343
Key HMO Key Choice	0343
Lifeguard, Inc.	0142
LA Care Health Plan	0355
Managed Health Network	0196
Maxicare	0002
MCC Behavioral Care of California, Inc.	0298
MedPartners Provider Network, Inc.	0345

Metrahealth Care Plan	0266
Merit Behavioral Care of California, Inc.	0288
Molina	0322
National Health Plans	0222
National HMO	0222
Omni Healthcare, Inc.	0238
One Health Plan of California Inc.	0325
On Lok Senior Health Services	0385
Pacificare Behavioral Health of California Inc.	0301
Pacificare of California	0126
Primecare Medical Network, Inc. A CA. Corp.	0367
Priorityplus of California	0237
Prucare Plus	0296
Qualmed Plans for Health/Bridgeway	0300
Regents of the University of California	0354
San Francisco Health Plan	0349
Santa Clara Family Health Plan	0351
Scripps Clinic Health Plan Services, Inc.	0377
Secure Horizons	0126
Sharp Health Plan	0310
Simnsa Health Care	0393
Sistemas Medicos Nacionales, S.A. De C.V.	0393
Smartcare Health Plan	0212
The Health Plan of San Joaquin	0338
Thipa Management Consultants, Incorporated	0363
Tower Health Service	0324
UHC Healthcare	0266
UHP Healthcare	0008
Universal Care	0209
Valley Health Plan	0236
Value Behavioral Health & American Psychol.	0293
Ventura County Health Care Plan	0344
Vista Behavioral Health Plan	0102
Western Health Advantage	0348
Other HMO	8000

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers: For use with discharges occurring in 2000

Name of Medi-Cal County Organized Health System	Plan Code Numbers
Cal Optima (Orange County)	9030
Health Plan of San Mateo (San Mateo County)	9041
Santa Barbara Health Authority (Santa Barbara County)	9042
Central Coast Alliance For Health Options (Santa Cruz County)	9044
Solano Partnership Health Plan (Solano County)	9048

APPENDIX D

LAW

CALIFORNIA HEALTH AND SAFETY CODE

DIVISION 107
STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PART 5
HEALTH DATA

CHAPTER 1
HEALTH FACILITY DATA

[Part 5 was added by Stats. 1995, c. 415 (S.B. 1360), § 9.]

CALIFORNIA HEALTH AND SAFETY CODE

128810. Administration; rules and regulations.
128812 Plan of data interchange.
128815. Duration of part.
127280. Special fee charged to health facilities; California Health Data and Planning Fund; failure to pay fees

§ 128675. Popular name of chapter

This chapter shall be known as the Health Data and Advisory Council Consolidation Act.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former ɜ 443, added by Stats. 1984, c. 1326, § 7.)

§ 128680. Legislative findings, declarations and intent

The Legislature hereby finds and declares that:

(a) Significant changes have taken place in recent years in the healthcare marketplace and in the manner of reimbursement to health facilities by government and private third-party payers for the services they provide.

(b) These changes have permitted the state to reevaluate the need for, and the manner of data collection from health facilities by the various state agencies and commissions.

(c) It is the intent of the Legislature that as a result of this reevaluation that the data collection function be consolidated in the single state agency. It is the further intent of the Legislature that the single state agency only collect that data from health facilities that are essential. The data should be collected, to the extent practical on consolidated, multipurpose report forms for use by all state agencies.

(d) It is the further intent of the Legislature to eliminate the California Health Facilities Commission and the State Advisory Health Council, and to create a single advisory commission to assume consolidated data collection and planning functions.

(e) It is the Legislature's further intent that the review of the data that the state collects be an ongoing function. The office, with the advice of the advisory commission, shall annually review this data for need and shall revise, add, or delete items as necessary. The commission and the office shall consult with affected state agencies and the affected industry when adding or eliminating data items. However, the office shall neither add nor delete data items to the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or judicial decision.

(f) The Legislature recognizes that the authority for the California Health Facilities Commission is scheduled to expire January 1, 1986. It is the intent of the Legislature, by the enactment of this chapter, to continue the uniform system of accounting and reporting established by the commission and required for use by health facilities. It is also the intent of the Legislature to continue an appropriate, cost-disclosure program.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former 443.10, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1985, c. 1021, § 15.)

§ 128681. Comprehensive review of the financial and utilization reports

The office shall conduct, under contract with a qualified consulting firm, a comprehensive review of the financial and utilization reports that hospitals are required to file with the office and similar reports required by other departments of state government, as appropriate. The contracting consulting firm shall have a strong commitment to public health and healthcare issues, and shall demonstrate fiscal management and analytical expertise. The purpose of the review is to identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different departments, and to consolidate reports wherever practical. The contracting consulting firm shall evaluate specific reporting requirements, exceptions to and exemptions from the requirements, and areas of duplication or overlap within the requirements. The contracting consulting firm shall consult with a broad range of data users, including, but not limited to, consumers, payers, purchasers, providers, employers, employees, and the organizations that represent the data users. It is expected that the review will result in greater efficiency in collecting and disseminating needed hospital information to the public and will reduce hospital costs and administrative burdens associated with reporting the information.

(Added by Stats. 1998, c. 735 (S.B. 1973) § 4.)

§ 128685. Intermediate care facilities/developmentally disabled - habilitative; exemption

Intermediate care facilities/developmentally disabled - habilitative, as defined in subdivision (e) of Section 1250, are not subject to this chapter.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.15, added as § 441.21 by Stats. 1987, c. 1456, § 1, renumbered § 443.15 and amended by Stats. 1990, c. 216 (S.B. 2510), § 49.)

§ 128690. Intermediate care facilities/developmentally disabled - nursing; exemption

Intermediate care facilities/developmentally disabled - nursing, as defined in subdivision (h) of Section 1250, are not subject to this chapter.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9.) Former 443.16, added as § 441.22 by Stats. 1985, c. 1496, § 3, renumbered § 443.16 and amended by Stats. 1990, c. 216 § 50.)

§ 128695. California Health Policy and Data Advisory Commission; creation; membership; terms

There is hereby created the California health policy and data advisory commission to be composed of 13 members.

The Governor shall appoint nine members, one of whom shall be a hospital chief executive officer, one of whom shall be a chief executive officer of a hospital serving a disproportionate share of low-income patients, one of whom shall be a long-term care facility chief executive officer, one of whom shall be a freestanding ambulatory surgery clinic chief executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group prepayment healthcare service plan, one of whom shall be a representative of a business coalition concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor coalition concerned with health, and one of whom shall be a general member.

The Governor shall designate a member to serve as chairperson for a two-year term. No member may serve more than two, two-year terms as chairperson. All appointments shall be for four-year terms. No individual shall serve more than two, four-year terms.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 437, added by Stats. 1971, c. 1217, § 2, amended by Stats. 1976, c.854, § 1; Stats. 1977, c. 206, § 1. Former § 437, added by Stats. 1967, c. 1597, § 1, amended by Stats. 1969, c. 1550, § 1; Stats. 1971, c. 1217, § 1; Stats. 1971, c. 1953, § 120. Former § 437.1, added by Stats. 1967, c. 1597, § 1, amended by Stats. 1969, c. 1550, § 2; Stats. 1971, c. 1217, § 3; Stats. 1971, c. 1593, § 122; Stats. 1976, c. 854, § 2. Former § 443.20, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1998, c. 735 (S.B. 1973) § 5.)

§ 128700. Definitions

As used in this chapter, the following terms mean:

(a) "Ambulatory surgery procedures" mean those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic.

(b) "Commission" means the California Health Policy and Data Advisory Commission.

(c) "Emergency department" means, in a hospital licensed to provide emergency medical services, the location in which those services are provided.

(d) "Encounter" means a face-to-face contact between a patient and the provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient.

(e) "Freestanding ambulatory surgery clinic" means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204.

(f) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(g) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

(h) "Office" means the Office of Statewide Health Planning and Development.

(i) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures that have been adjusted for demographic and clinical factors.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former 443.21, added by Stats. 1985, c. 1021, § 2, amended by Stats. 1988, c. 1478, § 2; Stats. 1991, c. 1075, § 2, amended by Stats. 1998, c. 735 (S.B. 1973) § 5.)

§ 128705. Reference to Advisory Health Council

On and after January 1, 1986, any reference in this code to the Advisory Health Council shall be deemed a reference to the California Health Policy and Data Advisory Commission.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former 443.22, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1989, c. 898, § 4.)

§ 128710. Meetings

The California Health Policy and Data Advisory Commission shall meet at least once every two months, or more often if necessary to fulfill its duties.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 437.2, added by Stats. 1967, c. 1597, § 1, amended by Stats. 1969, c. 371, § 30; Stats. 1969, c. 1550, ɔ 3; Stats. 1971, c. 1593, § 123; Stats. 1976, c. 854, § 2.5. Former § 443.23, added by Stats. 1984, c. 1326, § 7.)

§ 128715. Per diem and expenses

The members of the commission shall receive per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties and shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the commission.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 437.3, added by Stats. 1967, c. 1597, § 1, amended by Stats. 1971, c. 1593, § 124; Stats. 1976, c. 854, § 2.7. Former § 443.24, added by Stats. 1984, c. 1326, § 7.)

§ 128720. Executive Secretary; staff to commission

The commission may appoint an executive secretary subject to approval by the Secretary of Health and Welfare. The office shall provide such other staff to the commission as the office and the commission deem necessary.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 437.4, added by Stats. 1967, c. 197, § 1, amended by Stats. 1969, c. 1550, § 4. Former § 443.25, added by Stats. 1984, c. 1326, § 7.)

§ 128725. Powers and duties of commission; appointment and duties of committees; office and commission disagreements

The functions and duties of the commission shall include the following:

(a) Advise the office on the implementation of the new, consolidated data system.

(b) Advise the office regarding the ongoing need to collect and report health facility data and other provider data.

(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Health Welfare Committee and to the Assembly Health Committee.

(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.

(e) Conduct public meetings for the purposes of obtaining input from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.

(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the office of Administrative Law.

(h) Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.

(i) Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(j) Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.

(k) (1) The Technical Advisory Committee appointed pursuant to subdivision (j) shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision (d) of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.

(2) The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision (a) of Section 128745 no later than January 1, 1993. The Technical Advisory Committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical advisory committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.

(l) (1) Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following:

(A) Eliminate redundant reporting.

(B) Eliminate collection of unnecessary data.

(C) Augment data bases as deemed valuable to enhance the quality and usefulness of data.

(D) Standardize data elements and definitions with other health data collection programs at both the state and national levels.

(E) Enable linkage with, and utilization of, existing data sets.

(F) Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.

(G) Improve the timeliness of reporting and public disclosure.

(2) The commission shall establish a committee to implement the evaluation process. The committee shall include representatives from the healthcare industry, providers, consumers, payers, purchasers, and government entities, including the Department of Corporations, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.

(3) In order to ensure the timely implementation of the provisions of the legislation enacted in the 1997-98 Regular Session that amended this part, the office shall present an implementation work plan to the commission. The work plan shall clearly define goals and significant steps within specified timeframes that must be completed in order to accomplish the purposes of that legislation. The office shall make periodic progress reports based on the work plan to the commission. The commission may advise the Secretary of Health and Welfare of any significant delays in following the work plan. If the commission determines that the office is not making significant progress toward achieving the goals outlined in the work plan, the commission shall notify the office and the secretary of that determination. The commission may request the office to submit a plan of correction outlining specific remedial actions and timeframes for compliance. Within 90 days of notification, the office shall submit a plan of correction to the commission.

(m) (1) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.

(2) Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.

(3) The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

(Formerly § 443.26, added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1991, c. 1075 (A.B. 524) § 3; Stats. 1995, c. 543 (S.B. 1109), § 2, eff. Oct. 4, 1995. Renumbered § 128725 and amended by Stats. 1996, c. 1023 (S.B. 1497), § 141, eff. Sept. 29, 1996, amended by Stats. 1998, c. 735 (S.B. 1973) § 7.)

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§ 128730. Single state agency; collection of health facility or clinical data; consolidation of reports

(a) Effective January 1, 1986, the office shall be the single state agency designated to collect the following health facility or clinic data for use by all state agencies:

(1) That data required by the office pursuant to Section 127285.

(2) That data required in the Medi-Cal cost reports pursuant to Section 14170 of the Welfare and Institutions Code.

(3) Those data items formerly required by the California Health Facilities Commission that are listed in Sections 128735 and 128740. Information collected pursuant to subdivision (g) of Section 128735 shall be made available to the State Department of Health Services. The state department shall ensure that the patient's rights to confidentiality shall not be violated in any manner. The state department shall comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

(b) The office shall consolidate any and all of the reports listed under this section or Sections 128735 and 128740, to the extent feasible, to minimize the reporting burdens on hospitals. Provided, however, that the office shall neither add nor delete data items from the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or regulation or judicial decision.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former э 443.30, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1994, c. 1063, § 1.)

§ 128735. Health facilities; reports; exemptions from disclosure requirements; liability; hospital discharge abstract data record; patient confidentiality

Every organization that operates, conducts, or maintains a health facility, and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office that shall be in accord where applicable with the systems of accounting and uniform reporting required by this part, except the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760 are not required to report revenue by revenue center.

(d) A statement of cash-flows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760.

(f) Data reporting requirements established by the office shall be consistent with national standards, as applicable.

(g) A Hospital Discharge Abstract Data Record that includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) ZIP Code.

(5) Patient social security number, if it is contained in the patient's medical record.

(6) Prehospital care and resuscitation, if any, including all of the following:

(A) "Do not resuscitate" (DNR) order at admission.

(B) "Do not resuscitate" (DNR) order after admission.

(7) Admission date.

(8) Source of admission.

(9) Type of admission.

(10) Discharge date.

(11) Principal diagnosis and whether the condition was present at admission.

(12) Other diagnoses and whether the conditions were present at admission.

(13) External cause of injury.

(14) Principal procedure and date.

(15) Other procedures and dates.

(16) Total charges.

(17) Disposition of patient.

(18) Expected source of payment.

(19) Elements added pursuant to Section 128738.

(h) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (g).

(j) A hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

(Amended by Stats. 1996, c. 1025 (S.B. 1659), § 2. Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.31, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1984, c. 1338, § 1; Stats. 1985, c. 756, § 1; Stats. 1985, c. 1021, § 4; Stats. 1988, c. 1140, § 1; Stats. 1993, c. 249, § 1; Stats. 1994, c. 1063, § 2, amended by Stats. 1998, c. 735 (S.B.

1973) § 8.)

§ 128736 Hospital emergency care data record

(a) Each hospital shall file an Emergency Care Data Record for each patient encounter in a hospital emergency department. The Emergency Care Data Record shall include all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) Ethnicity.

(5) ZIP Code.

(6) Patient social security number, if it is contained in the patient's medical record.

(7) Service date.

(8) Principal diagnosis.

(9) Other diagnoses.

(10) Principal external cause of injury.

(11) Other external cause of injury.

(12) Principal procedure.

(13) Other procedures.

(14) Disposition of patient.

(15) Expected source of payment.

(16) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (a).

(d) Data reporting requirements established by the office shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2002.

(Added by Stats. 1998, c. 735 (S.B. 1973) § 9.)

§ 128737 Hospital and freestanding ambulatory surgery clinic and ambulatory surgery data record

(a) Each hospital and freestanding ambulatory surgery clinic shall file an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed. The Ambulatory Surgery Data Record shall include all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) Ethnicity.

(5) ZIP Code.

(6) Patient social security number, if it is contained in the patient's medical record.

(7) Service date.

(8) Principal diagnosis.
(9) Other diagnoses.

(10) Principal procedure.

(11) Other procedures.

(12) Principal external cause of injury, if known.

(13) Other external cause of injury, if known.

(14) Disposition of patient.

(15) Expected source of payment.

(16) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (a).

(d) Data reporting requirements established by the office shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2002.

(Added by Stats. 1998, c. 735 (S.B. 1973) § 10.)

§ 128738 Additions or deletions to the patient level data elements

(a) The office, based upon review and recommendations of the commission and its appropriate committees, shall allow and provide for, in accordance with appropriate regulations, additions or deletions to the patient level data elements listed in subdivision (g) of Section 128735, Section 128736, and Section 128737, to meet the purposes of this chapter.

(b) Prior to any additions or deletions, all of the following shall be considered:

(1) Utilization of sampling to the maximum extent possible.

(2) Feasibility of collecting data elements.

(3) Costs and benefits of collection and submission of data.

(4) Exchange of data elements as opposed to addition of data elements.

(c) The office shall add no more than a net of 15 elements to each data set over any five-year period. Elements contained in the uniform claims transaction set or uniform billing form required by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg) shall be exempt from the 15-element limit.

(d) The commission and the office, in order to minimize costs and administrative burdens, shall consider the total number of data elements required from hospitals and freestanding ambulatory surgery clinics, and optimize the use of common data elements.

(Added by Stats. 1998, c. 735 (S.B. 1998) § 11.)

§ 128740. Quarterly summary financial and utilization data reports; contents; copies; charity care service guidelines

(a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.
(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent

programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.

(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Non-operating revenue net of non-operating expenses.

(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10), (14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.

(c) The office shall make available at cost, to all interested parties, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(d) The office, with the advice of the commission, shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional healthcare industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

This section shall become operative January 1, 1992.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former э 443.32, added by Stats. 1989, c. 1331, § 1.2, amended by Stats. 1990, c. 51, § 1.5; Stats. 1990, c. 51, § 2; Stats. 1991, c. 278, § 1.4; Stats. 1991, c. 278, § 1.5.)

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§ 128745. Annual risk-adjusted outcome reports; schedule; criteria; groupings

(a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988-90	3
July 1994	1989-91	6
July 1995	1990-92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions to be reported shall be divided equally among medical, surgical and obstetric conditions or procedures and shall be selected by the office, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings:

(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.

(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.

(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.

(4) "Lower than average outcomes," for hospitals with risk-adjusted outcomes lower than the norm.

(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.321, added by Stats. 1991, c. 1075, § 4.)

§ 128750. Preliminary report to hospital included in annual outcome report; explanatory statement; additional information; technical advisory committee duties

(a) Prior to the public release of the annual outcome reports the office shall furnish a preliminary report to each hospital that is included in the report. The office shall allow the hospital and chief of staff 60 days to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the office, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.

(b) The office shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.

(c) If, pursuant to the recommendations of the office, based on the advice of the commission, in response to the recommendations of the technical advisory committee made pursuant to subdivision (d) of this section, the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available for the current abstract record will be produced following the collection and analysis of the additional data elements.

(d) The recommendations of the technical advisory committee for the addition of data elements to

the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the technical advisory committee with the advice of the research community, physicians and surgeons, hospitals, and medical records personnel.

(e) The technical advisory committee at a minimum shall identify a limited set of core clinical data elements to be collected for all of the added procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the committee should give careful consideration to the costs associated with the additional data collection and the value of the specific information to be collected.

(f) The technical advisory committee shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.322, added by Stats. 1991, c. 1075, § 5.)

§ 128755. Reports required; filing; availability

(a) (1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the hospital's fiscal year except as provided in paragraph (2).

(2) If a licensee relinquishes the facility license or puts the facility license in suspense, the last day of active licensure shall be deemed a fiscal year end.

(3) The office shall make the reports filed pursuant to this subdivision available no later than three months after they were filed.

(b) (1) Skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, and congregate living facilities, including nursing facilities certified by the state department to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the facility's fiscal year, except as provided in paragraph (2).

(2) (A) If a licensee relinquishes the facility license or puts the facility licensure in suspense, the last day of active licensure shall be deemed a fiscal year end.

(B) If a fiscal year end is created because the facility license is relinquished or put in suspense, the facility shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 within two months after the last day of active licensure.

(3) The office shall make the reports filed pursuant to paragraph (1) available not later than three months after they are filed.

(4) (A) Effective for fiscal years ending on or after December 31, 1991, the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 shall be filed with the office by electronic media, as determined by the office.

(B) Congregate living health facilities are exempt from the electronic media reporting requirements of subparagraph (A).

(c) A hospital shall file the reports required by subdivision (g) of Section 128735 as follows:

(1) For patient discharges on or after January 1, 1999, through December 31, 1999, the reports shall be filed semiannually by each hospital or its designee not later than six months after the end of each semiannual period, and shall be available from the office no later than six months after the date that the report was filed.

(2) For patient discharges on or after January 1, 2000, through December 31, 2000, the reports shall be filed semiannually by each hospital or its designee not later than three months after the end of each semiannual period. The reports shall be filed by electronic tape, diskette, or similar medium as approved by the office. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(3) For patient discharges on or after January 1, 2001, the reports shall be filed by each hospital or its designee for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(d) The reports required by subdivision (a) of Section 128736 shall be filed by each hospital for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the ffice, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the report is approved.

(e) The reports required by subdivision (a) of Section 128737 shall be filed by each hospital or freestanding ambulatory surgery clinic for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as

filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the report is approved.

(f) Facilities shall not be required to maintain a full-time electronic connection to the office for the purposes of online transmission of reports as specified in subdivisions (c), (d), and (e). The office may grant exemptions to the online transmission of data requirements for limited periods to facilities. An exemption may be granted only to a facility that submits a written request and documents or demonstrates a specific need for an exemption. Exemptions shall be granted for no more than one year at a time, and for no more than a total of five consecutive years.

(g) The reports referred to in paragraph (2) of subdivision (a) of Section 128730 shall be filed with the office on the dates required by applicable law and shall be available from the office no later than six months after the date that the report was filed.

(h) The office shall make available to all interested parties a copy of any report referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, and Section 128740 and, in addition, shall make available in electronic formats reports referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, and Section 128740 unless the office determines that an individual patient's rights of confidentiality would be violated. The office shall make the reports available at cost.

(Added by Stats. 1995, c. 415 (S.B. 1360) § 9. Former § 443.33, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1985, c. 1021, § 7; Stats. 1988, c. 1140, § 2; Stats. 1990, c. 502, § 1, amended by Stats. 1998, c. 735 (S.B. 1973) § 12.)

§ 128760. Health facilities; accounting and auditing systems; modifications to discharge data reporting requirements; reporting provisions; county hospital systems financial reporting requirements

(a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office with the advice of the Health Policy and Data Advisory Commission.

(b) The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) Modifications to discharge data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) Modifications to emergency care data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) Modifications to ambulatory surgery data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not be construed to permit the office to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) Reporting provisions for health facilities. The office, with the advice of the commission, shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment healthcare service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner that is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

(g) Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 128735. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

(h) The office, with the advice of the commission, shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.34, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1984, c. 1338, § 2; Stats. 1985, c. 756, § 5, amended by Stats. 1998, c. 735 (S.B. 1973) § 13.)

§ 128765. File of reports; public inspection; certified copies; summaries; public liaison

(a) The office, with the advice of the commission, shall maintain a file of all the reports filed under this chapter at its Sacramento office. Subject to any rules the office, with the advice of the commission, may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, with the exception of hospital discharge abstract data that shall be available for public inspection unless the office determines that an individual patient's rights of confidentiality would be violated.

(b) Copies certified by the office as being true and correct, copies of reports properly filed with the office pursuant to this chapter, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission that participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal healthcare program. Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(c) The office, with the advice of the commission, shall compile and publish summaries of the data for the purpose of public disclosure. The commission shall approve the policies and procedures relative

to the manner of data disclosure to the public. The office, with the advice of the commission, may initiate and conduct studies as it determines will advance the purposes of this chapter.

(d) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director and the commission with an annual report on changes that can be made to improve the public's access to data.

(e) In addition to its public liaison function, the office shall continue the publication of aggregate industry and individual health facility cost and operational data published by the California Health Facilities Commission as described in subdivision (b) of Section 441.95 as that section existed on December 31, 1985. This publication shall be submitted to the Legislature not later than March 1 of each year commencing with calendar year 1986 and in addition shall be offered for sale as a public document.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.35, added by Stats. 1984, c. 1326, § 7, amended by Stats. 1985, c. 1021, § 8.)

§ 128770. Penalties; disposition

(a) Any health facility that does not file any report as required by this chapter with the office is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office, with the advice of the commission.

(b) Any health facility that does not use an approved system of accounting pursuant to the provisions of this chapter for purposes of submitting financial and statistical reports as required by this chapter shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of any health facility, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money which is received by the office pursuant to this section shall be paid into the General Fund.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former ɔ 443.36, added by Stats. 1984, c. 1326, § 7.)

§ 128775. Petition for review; hearing; judicial review; subpoena powers

(a) Any health facility affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within a greater time as the office, with the advice of the commission, may allow, and shall specifically

describe the matters which are disputed by the petitioner.

(b) A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, an administrative law judge employed by the Office of Administrative Hearings, or a committee of the commission chosen by the chairperson for this purpose. If held before an employee of the office or a committee of the commission, the hearing shall be held in accordance with any procedures as the office, with the advice of the commission, shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The employee, administrative law judge, or committee shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(c) Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

(d) The employee of the office, the administrative law judge employed by the Office of Administrative Hearings, the Office of Administrative Hearings, or the committee of the commission, may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Article 11 (commencing with Section 11450.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) This section shall become operative on July 1, 1997.

(Formerly § 443.37, added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1985, c. 1021, § 9; Stats. 1995, c. 938 (S.B. 523), § 59, operative July 1, 1997. Renumbered §

128775 and amended by Stats. 1996, c. 1023 (S.B. 1497), §141.4, eff. Sept. 29, 1996, operative July 1, 1997.)

§ 128780. District hospitals; completeness of disclosure

Notwithstanding any other provision of law, the disclosure aspects of this chapter shall be deemed complete with respect to district hospitals, and no district hospital shall be required to report or disclose any additional financial or utilization data to any person or other entity except as is required by this chapter.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.38, added by Stats. 1984, c. 1326, § 7.)

§ 128782. Small and rural hospitals; exemption from electronic filing requirements; one-time reduction in fee

Notwithstanding any other provision of law, upon the request of a small and rural hospital, as defined in Section 124840, the office shall do all of the following:

(a) If the hospital did not file financial reports with the office by electronic media as of January 1, 1993, the office shall, on a case-by-case basis, do one of the following:

(1) Exempt the small and rural hospital from any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(2) Provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer hardware and software necessary to comply with any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(b) The office shall provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer software and hardware necessary to comply with any electronic filing requirements of the office regarding reports specified in Sections 128735, 128736, and 128737.

(c) The office shall provide the hospital with assistance in meeting the requirements specified in paragraphs (1) and (2) of subdivision (c) of Section 128755 that the reports required by subdivision (g) of Section 128735 be filed by electronic media or by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of patient discharge abstract data records. The program or software shall incorporate validity checks and edit standards.

(d) The office shall provide the hospital with assistance in meeting the requirements specified in subdivision (d) of Section 128755 that the reports required by subdivision (a) of Section 128736 be filed by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of emergency care data records. The program or software shall incorporate validity checks and edit standards.

(e) The office shall provide the hospital with assistance in meeting the requirements specified in subdivision (e) of Section 128755 that the reports required by subdivision (a) of Section 128737 be filed by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of ambulatory surgery data records. The program or software shall incorporate validity checks and edit standards.

(Added by Stats. 1996, c. 1023 (S.B. 1497), § 369, eff. Sept. 29, 1996, amended by Stats. 1998, c. 735 (S.B. 1973) § 14.)

§ 128785. Regulations to remain in effect

On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission that relate to functions vested in the office and that are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this chapter, as determined by the office, unless and until readopted, amended, or repealed by the office following review and comment by the commission.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.40, added by Stats. 1984, c. 1326, § 7.)

§ 128790. Transfer of funds

Pursuant to Section 16304.9 of the Government Code, the Controller shall transfer to the office the unexpended balance of funds as of January 1, 1986, in the California Health Facilities Commission Fund, available for use in connection with the performance of the functions of the California Health Facilities Commission to which it has succeeded pursuant to this chapter.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.41, added by Stats. 1984, c. 1326, § 7.)

§ 128795. Transfer of officers and employees other than temporary employees

All officers and employees of the California Health Facilities Commission who, on December 31, 1985, are serving the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the office by this chapter shall be transferred to the office. The status, positions, and rights of such persons shall not be affected by the transfer and shall be retained by them as officers and employees of the office, pursuant to the State Civil Service Act except as to positions exempted from civil service.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.42, added by Stats. 1984, c. 1326, § 7.)

§ 128800. Transfer of real and personal property of California health facilities commission

The office shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, land, or other property, real or personal, held for the benefit or use of the California Health Facilities Commission for the performance of functions transferred to the office by this chapter.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.43, added by Stats. 1984, c. 1326, § 7.)

§ 128805. Contracts

The office may enter into agreements and contracts with any person, department, agency, corporation, or legal entity as are necessary to carry out the functions vested in the office by this chapter or any other law.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former §ɜ 443.44, added by Stats. 1984, c. 1326, § 7.)

§ 128810. Administration; rules and regulations

The office shall administer this chapter and shall make all rules and regulations necessary to implement the provisions and achieve the purposes stated herein. The commission shall advise and consult with the office in carrying out the administration of this part.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 443.45, added by Stats. 1984, c. 1326, § 7.)

§ 128812 Plan of data interchange

On or before June 30, 2001, the office shall submit to the Legislature a plan to achieve the goal of data interchange between and among health facilities, healthcare service plans, insurers, providers, emergency medical services providers and local emergency medical services agencies, and other state agencies in California. Implementation of the plan shall begin no later than July 1, 2002. On or before June 30, 2002, the office shall submit a progress report to the Legislature, including the status of the data interchange capabilities facilitated by the office. The office, with the advice of the commission, shall engage a qualified outside consulting organization to evaluate progress made by the office and make recommendations to the Legislature by June 30, 2003.

(Added by Stats. 1998, c. 735 (S.B. 1973) § 15.)

§ 128815 Duration of part

SEC. 16. Section 128815 of the Health and Safety Code is amended to read:

This chapter shall remain operative only until June 30, 2004, and as of January 1, 2005, is repealed, unless a later enacted statute, chaptered prior to that date, extends or deletes that date.

SEC. 17. The sum of one million two hundred forty thousand five hundred dollars ($1,240,500) is hereby appropriated from the California Health Planning and Data Fund, without regard to fiscal year, to the Office of Statewide Health Planning and Development for allocation as follows:

(a) The sum of two hundred fifty thousand dollars ($250,000) for the purpose of conducting a comprehensive review of hospital reporting requirements to the state.

(b) The sum of nine hundred ninety thousand five hundred dollars ($990,500) for the systems development costs associated with improving the timeliness of the patient discharge data program and the collection of ambulatory surgery and emergency department records.

(Formerly § 443.46, added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1988, c. 1140, § 3; Stats. 1995, c. 543 (S.B. 1109), § 3, eff. Oct. 4, 1995. Renumbered § 128815 and amended by Stats. 1996, c. 1023 (S.B. 1497), § 142, eff. Sept. 29, 1996, amended by Stats. 1998, c. 735 (S.B. 1973) § 16.)

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[The following section while not within Part 5, Chapter 1, is relevant to the Health Data and Advisory Council Consolidation Act.]

§ 127280 Special fee charged to health facilities; California Health Data and Planning Fund; failure to pay fees

[This version of Section 127180 is operative until January 1, 2002. The following version of Section 127280 will become operative January 1, 2002.]

(a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall be charged a fee of not more than 0.035 percent of the health facility's gross operating cost for the provision of healthcare services for its last fiscal year ending prior to the effective date of this section. Thereafter the office shall set for, charge to, and collect from all health facilities, except health facilities owned and operated by the state, a special fee, that shall be due on July 1, and delinquent on July 31 of each year beginning with the year 1977, of not more than 0.035 percent of the health facility's gross operating cost for provision of healthcare services for its last fiscal year that ended on or before June 30 of the preceding calendar year. Each year the office shall establish the fee to produce revenues equal to the appropriation to pay for the functions required to be performed pursuant to this chapter or Chapter 1 (commencing with Section 128675) of Part 5 by the office, the area and local health planning agencies, and the Advisory Health Council.

Health facilities that pay fees shall not be required to pay, directly or indirectly, the share of the costs of those health facilities for which fees are waived.

(b) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(c) Any amounts raised by the collection of the special fees provided for by subdivision (a) of this section that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office and the council in succeeding years when appropriated by the Legislature, for expenditure under the provisions of this chapter, and Chapter 1 (commencing with Section 128675) of Part 5 and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(d) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. New, previously unlicensed health facilities shall be charged a pro rata fee to be established by the office during the first year of operation.

The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (a).

(e) This section shall remain in effect only until January 1, 2002, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2002, deletes or extends that date.

CALIFORNIA HEALTH AND SAFETY CODE

§ 127280 Special fee charged to health facilities; California Health Data and Planning Fund; failure to pay fees

[This version of Section 127280 will become operative on January 1, 2002. The previous version of Section 127280 is operative until January 1, 2002.]

(a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Every freestanding ambulatory surgery clinic as defined in Section 128700 shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation to pay for the functions required to be performed pursuant to this chapter or Chapter 1 (commencing with Section 128675) of Part 5 by the office and the California Health Policy and Data Advisory Commission. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of healthcare services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of healthcare services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(2) (A) For the calendar year 2002 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2002 and shall report that number to the office by March 12, 2002. The estimate shall be as accurate as possible. The fee in the calendar year 2002 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents ($0.50) and shall be due on July 1 and delinquent on July 31, 2002.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2002 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2003 by the amount of the difference multiplied by fifty cents ($0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2003 by the amount of the

difference multiplied by fifty cents ($0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2003 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents ($0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar ($1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office and the commission in succeeding years when appropriated by the Legislature for expenditure under the provisions of this chapter and Chapter 1 (commencing with Section 128675) of Part 5, and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9. Former § 439, added by Stats. 1976, c. 854, § 31, amended by Stats. 1984, c. 1326, § 6; Stats. 1985, c. 1021, § 1; Stats. 1986, c. 1084, § 1; Stats. 1988, c. 67, § 1, amended by Stats. 1998, c. 735 (S.B. 1973) § 2.)

APPENDIX E

REGULATIONS

CALIFORNIA CODE OF REGULATIONS

TITLE 22

DIVISION 7

CHAPTER 10
HEALTH FACILITY DATA

ARTICLE 8
DISCHARGE DATA REPORTING REQUIREMENTS

97210. Notice of Change in Hospital Operations, Contact Person, Method of Submission or Designated Agent.

(a) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in the person designated as the patient discharge contact person or in the telephone number of the contact person.

(b) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in method of submission or change in designated agent for the purpose of submitting the hospital's discharge data report. If there is a change in designated agent, the hospital or its new designated agent must comply with Section 97215. A hospital may submit its own discharge data report directly to the Office's Discharge Data Program, or it may designate an agent for this purpose.

(c) Each hospital beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Office's Discharge Data Program within 30 days after its first day of operation of its: designated agent for the purpose of submitting the hospital's discharge data report (if it chooses not to submit its discharge data report directly), method of submission, contact person, and telephone number of contact person. The hospital shall be provided a unique identification number that it can report pursuant to Section 97239. Pursuant to Section 97215, the hospital, if it chooses to designate itself to submit its discharge data report, and its method of submission is not Manual Abstract Reporting Form (OSHPD 1370), shall submit a set of test data that is in compliance with the required format. Pursuant to Section 97215, any agent the hospital designates to submit its discharge data report on its behalf must have submitted a test set of data that is in compliance with the required format, prior to the due date of the hospital's first reporting period.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97211. Reporting Periods and Due Dates.

(a) The prescribed reporting period is calendar semiannual, which means that there are two reporting periods each year, consisting of discharges occurring January 1 through June 30 and discharges occurring July 1 through December 31. The prescribed due dates are six months after the end of each reporting period; thus, the due date for the January 1 through June 30 reporting period is December 31 of the same year, and the due date for the July 1 through December 31 reporting period is June 30 of the following year.

(b) Where there has been a change in the licensee of a hospital, the effective date of the change in licensee shall constitute the start of the reporting period for the new licensee, and this first reporting period shall end on June 30 or December 31, whichever occurs first. The final day of the reporting period for the previous licensee shall be the last day their licensure was effective, and the due date for the discharge data report shall be six months after the final day of this reporting period.

(c) Discharge data reports shall be filed, as defined by Section 97005, by the date the discharge data report is due. Where a hospital has been granted an extension, pursuant to Section 97241, the

ending date of the extension shall constitute the new due date for that discharge data report.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97212. Definitions, as used in this Article.

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code.

(b) Computer Media. Computer media means computer tape (reel or cartridge), diskette, or compact disk.

(c) Designated Agent. An entity designated by a hospital to submit that hospital's discharge data records to the Office's Discharge Data Program; may include the hospital's abstractor, a data processing firm, or the data processing unit in the hospital's corporate office.

(d) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one type of care to another type of care, as defined by Subsection (i) of Section 97212, or

(3) has died.

(e) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Healthcare Financing Administration.

(f) Do Not Resuscitate (DNR) Order. A DNR order is a directive from a physician in a patient's current inpatient medical record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following: cardiopulmonary resuscitation (CPR), intubation, defibrillation, cardioactive drugs, or assisted ventilation.

(g) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Healthcare Financing Administration, the National Center for Health Statistics, and the American Health Information Management Association).

(h) Method of Submission. A method of submission is the medium used by a hospital or its designated agent to submit a discharge data report to the Office and may be one of the following:

(1) computer tape (reel or cartridge),

(2) diskette,

(3) compact disk, or

(4) Manual Abstract Reporting Form (OSHPD 1370).

(i) Type of Care. Type of care is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classifications of skilled nursing or intermediate care, as defined by Subdivisions (a)(2), (a)(3), or (a)(4), of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Physical rehabilitation care. included on a hospital's license within the general acute care classification, as defined by Subdivision Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds (a)(1) of Section 1250.1 of the Health and Safety Code, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 and of Section 70595.

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification of acute psychiatric beds, as defined by Subdivision (a)(5) of Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined by Subdivision (a) of Section 1250.2 of the Health and Safety Code.

(4) Chemical dependency recovery care. Chemical dependency recovery care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as chemical dependency recovery beds, as defined by Subdivision (a)(7) of Section 1250.1 and Subdivisions (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

(5) Acute care. Acute care, as defined by Subdivision (a)(1) of Section 1250.1 of the Health and Safety Code, means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital, other than those defined by Subsections (i)(1), (i)(2), (i)(3), and (i)(4) of this section.

(j) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined by Subdivision (c) of Section 128700 of the Health and Safety Code.

(k) Record. A record is defined as the set of data elements of the "hospital discharge abstract data

record," as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for one patient.

(l) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period or for a shorter period, pursuant to Subsection (b) of Section 97211.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 1250, and 1250.1, Health and Safety Code.

97213. Required Reporting.

(a) Each hospital shall submit the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual reporting period, according to the format specified in Section 97215 and by the dates specified in Section 97211.

(b) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the acute care type of care, as defined by Subsection (i)(5) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "1" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "1" in the first position on each of these records.

(c) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care type of care, as defined by Subsection (i)(1) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "3" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "3" in the first position on each of these records.

(d) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the psychiatric care type of care, as defined by Subsection (i)(3) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "4" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "4" in the first position on each of these records.

(e) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the chemical dependency recovery care type of care, as defined by Subsection (i)(4) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "5" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "5" in the first position on each of these records.

(f) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the physical rehabilitation care type of care, as defined by Subsection (i)(2) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "6" in the space provided. If submitted on computer media, the hospital shall identify these records by recording a "6" in the first position on each of these records.

(g) Each discharge data report shall be submitted at one time, use one method of submission, and shall include all types of care.

(h) A hospital operating under a consolidated license may submit its discharge data report in separate sets of records that relate to separate physical plants.

(i) If a hospital operating under a consolidated license submits its report in separate sets of records, the compilation of those sets must include all discharge records from all types of care and from all physical plants on that hospital's license. The complete compilation of sets of records for a hospital comprises that hospital's discharge data report for purposes of this Article.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97214. Form of Authentication.

(a) Hospitals submitting their hospital discharge abstract data records using the Manual Abstract Reporting Forms (OSHPD 1370) must submit with each discharge data report a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, as specified in Section 97239, the reporting period's beginning and ending dates, the number of records, and the following statement of certification, to be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ _____
(Name of hospital)

By: _____

Title: _____

Address: _____

A hospital that uses the Individual Hospital Transmittal Form (OSHPD 1370.1) is not required to submit a separate Discharge Data Certification Form (OSHPD 1370.3).

(b) Hospitals submitting their hospital discharge abstract data records using computer media must submit with each discharge data report a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, as specified in Section 97239, the reporting period's beginning and ending dates, the number of records, the tape specifications, and the signed statement of certification, as specified in Subsection (a) of Section 97214.

(c) Hospitals that designate an agent to submit their hospital discharge abstract data records must submit for each discharge data report a Discharge Data Certification Form (OSHPD 1370.3) to the Office's Discharge Data Program. This form shall be mailed after the end of each reporting period, and before that corresponding reporting period's due date. The certification must cover the same reporting period as the data submitted by the designated agent. This form, that contains the following statement of certification, shall be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the discharge abstract data records submitted to (name of my hospital's designated agent) for the period from (starting date) to (ending date) are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ _____

(Name of hospital)

By: _____

Title: _____

Address: _____

(d) Agents who have been designated by a hospital through the Discharge Data Certification Form (OSHPD 1370.3) to submit that hospital's discharge abstract data records must submit with each discharge data report a completed Agent's Transmittal Form (OSHPD 1370.2), including the following information clearly indicated: the hospital name, the hospital identification number, the reporting period's beginning and ending dates, the number of records, and the tape specifications. If the computer tape contains more than 13 reports, page two of the Agent's Transmittal Form (OSHPD 1370.2) shall be completed and attached to page one.

Designated agents are not required to submit any certification forms.

(e) Any hospital or designated agent may obtain free copies of the Individual Hospital Transmittal form (OSHPD 1370.1), the Agent's Transmittal Form (OSHPD 1370.2), and the Discharge Data Certification Form (OSHPD 1370.3) by contacting the Office's Discharge Data Program.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97215. Format.

Patient discharge data shall be reported to the Office's Discharge Data Program on either the Manual Abstract Reporting Form (OSHPD 1370) or on computer media. The version of the Manual Abstract Reporting Form (OSHPD 1370) to be used depends on the date of discharge: discharges January 1, 1997, through December 31, 1998, shall use Form 1370 as revised June 1996, and discharges on or after January 1, 1999, shall use Form 1370 as revised in March 1998. The Office shall furnish each hospital using Form 1370 a copy of the appropriate version in advance of the start of each reporting period. Additional copies of Form 1370 shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

The format and specifications for the computer media depend on the date of discharge: discharges January 1, 1997, through December 31, 1998, shall comply with the Office's standard format and specifications as revised September 1, 1995, and discharges on or after January 1, 1999, shall comply with the Office's standard format and specifications as revised in March 1998. The Office shall furnish each hospital and designated agent a copy of the standard format and specifications before the start of the reporting period to which revisions apply. Additional copies may be obtained at no charge from the Office's Discharge Data Program.

Each hospital whose discharge data is submitted on computer media or, if the hospital has designated an agent, that agent, shall demonstrate its ability to comply with the standard format and specifications by submission of a test file of its data with which the Office can confirm compliance with the standard format and specifications.

The test file shall be submitted at least 60 days prior to the next reporting period due date by new hospitals or by existing hospitals after a change in any of the following: the Office's standard format and specifications; the hospital's or its designated agent's computer system, hardware or software; the computer media used by the hospital or its designated agent, the method of submission; or the designated agent, unless the new designated agent has already submitted a test file that complied with the standard format and specifications.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97216. Definition of Data Element—Date of Birth.

The patient's birth date shall be reported in numeric form as follows: the 2-digit month, the

2-digit day, and the 4-digit year of birth. The numeric form for days and months from 1 to 9 must have a zero as the first digit. When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth shall be reported. If only the age is known, the estimated year of birth shall be reported. If the month and year of birth are known, and the exact day is not, the year, the month, and zeros for the day shall be reported.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97217. Definition of Data Element—Sex.

The patient's gender shall be reported as male, female, other, or unknown. "Other" includes sex changes, undetermined sex, and live births with congenital abnormalities that obscure sex identification. "Unknown" indicates that the patient's sex was not available from the medical record.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97218. Definition of Data Element—Race.

Effective with discharges on January 1, 1995, the patient's ethnic and racial background shall be reported as one choice from the following list of alternatives under ethnicity and one choice from the following list of alternatives under race:

(a) Ethnicity:

(1) Hispanic. A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

(2) Non-Hispanic.

(3) Unknown.

(b) Race:

(1) White. A person having origins in or who identifies with any of the original caucasian peoples of Europe, North Africa, or the Middle East.

(2) Black. A person having origins in or who identifies with any of the black racial groups of Africa.

(3) Native American/Eskimo/Aleut. A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

(4) Asian/Pacific Islander. A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

(5) Other. Any possible options not covered in the above categories.

(6) Unknown.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97219. Definition of Data Element—ZIP Code.

The "ZIP Code," a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient's usual residence shall be reported for each patient discharge. Foreign residents shall be reported as "YYYYY" and unknown ZIP Codes shall be reported as "XXXXX." If the city of residence is known, but not the street address, report the first three digits of the ZIP Code, and the last two digits as zeros. Hospitals shall distinguish the "homeless" (patients who lack a residence) from other patients lacking a numeric ZIP Code of residence by reporting the ZIP Code of homeless patients as "ZZZZZ." If the patient has a
9-digit ZIP Code, only the first five digits shall be reported.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97220. Definition of Data Element—Patient Social Security Number.

The patient's social security number is to be reported as a 9-digit number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record," by reporting the social security number as "000000001." The number to be reported is to be the patient's social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital's bill is to be submitted.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97221. Definition of Data Element—Admission Date.

The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined by Subsection (i) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this record.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97222. Definition of Data Element—Source of Admission.

Effective with discharges on or after January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(a) The site from which the patient was admitted.

(1) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(2) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(3) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(4) Skilled Nursing/Intermediate Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility, as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

(5) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of a hospital.

(6) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(7) Newborn. A baby born alive in this hospital.

(8) Prison/Jail. A patient admitted from a correctional institution.

(9) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from a freestanding, not hospital-based, inpatient hospice facility.

(b) Licensure of the site.

(1) This Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(2) Another Hospital. The Ambulatory Surgery, Skilled Nursing/Intermediate Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

(3) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Skilled Nursing/Intermediate Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

(c) Route of admission.

(1) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of another hospital.

(2) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97223. Definition of Data Element—Type of Admission.

Effective with discharges on January 1, 1995, the patient's type of admission shall be reported using one of the following categories:

(a) Scheduled. Admission was arranged with the hospital at least 24 hours prior to the admission.

(b) Unscheduled. Admission was not arranged with the hospital at least 24 hours prior to the admission.

(c) Infant. An infant less than 24 hours old.

(d) Unknown. Nature of admission not known. Does not include stillbirths.
Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97224. Definition of Data Element—Discharge Date.

The patient's date of discharge shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97225. Definition of Data Element—Principal Diagnosis and Whether the Condition was Present at Admission.

(a) The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-9-CM.

(b) Effective with discharges on or after January 1, 1996, whether the patient's principal diagnosis was present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97226. Definition of Data Element—Other Diagnoses and Whether the Conditions were Present at Admission.

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the supplementary classification of external causes of injury and poisoning (E800-E999) shall not be reported as other diagnoses.

(b) Effective with discharges on or after January 1, 1996, whether the patient's other diagnoses were present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97227. Definition of Data Element—External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported only for the first inpatient hospitalization during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect first diagnosed and/or treated during the current inpatient hospitalization.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97228. Definition of Data Element—Principal Procedure and Date.

The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for

days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97229. Definition of Data Element—Other Procedures and Dates.

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. Procedures shall be coded according to the ICD-9-CM. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97230. Definition of Data Element—Total Charges.

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), report Total Charges for the last year (365 days) of stay only.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97231. Definition of Data Element—Disposition of Patient.

Effective with discharges on or after January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the reporting facility, shall be reported as one of the following:

(a) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office or a clinic shall be included. Excludes patients referred to a home health service.

(b) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit within this reporting hospital.

(c) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric,

physical medicine rehabilitation, or chemical dependency recovery treatment unit within this reporting hospital.

(d) Skilled Nursing/Intermediate Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(e) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of another hospital.

(f) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

(g) Skilled Nursing/Intermediate Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within another hospital, or to a Congregate Living Health Facility, as defined by Subsection (i) of Section 1250 of the Health and Safety Code.

(h) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized healthcare.

(i) Prison/Jail. A patient discharged to a correctional institution.

(j) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from away without leave (AWOL) status are included in this category.

(k) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(l) Home Health Service. A patient referred to a licensed home health service program.

(m) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a freestanding, not hospital-based, inpatient hospice facility.

97232. Definition of Data Element—Expected Source of Payment.

(a) Effective with discharges on or after January 1, 1999, the patient's expected source of payment shall be reported using the following:

(1) Payer Category: The type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill.

(A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

(B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

(C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners.

(D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

(E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds whether or not a bill is rendered.

(F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections (a)(1)(A), (a) (1)(B), (a)(1)(D), or (a) (1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

(G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (a)(1)(E) of this section.

(H) Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan.

(I) Other Payer. Any third party payment not included in Subsections (a) (1)(A) through (a)(1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

(2) Type of Coverage. For each Payer Category, Subsections (a)(1)(A) through (a)(1)(F) of this section, select one of the following Types of Coverage:

(A) Managed Care - Knox-Keene/Medi-Cal County Organized Health System. Health care service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Corporations under the Knox-Keene Health Care Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems.

(B) Managed Care - Other. Health care plans, except those in Subsection (a)(2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or

per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Exclusive Provider Organization with Point-of-Service option (POS).

(C) Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

(3) Name of Plan.

(A) For discharges occurring on or after January 1, 1999, up to and including discharges occurring on December 31, 1999, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan as shown in Table 1. or the Medi-Cal County Organized Health System as shown in Table 2.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers:
For use with discharges occurring in 1999

Plan Code Names	Plan Code Numbers
Aetna Health Plans of California, Inc.	0176
Alameda Alliance for Health	0328
American Family Care	0322
Blue Cross of California	0303
Blue Shield of California	0043
BPS HMO	0314
Brown and Toland Medical Group	0352
Calaveras Provider Network	0365
Care 1st Health Plan	0326
Careamerica-Southern California, Inc.	0234
Chinese Community Health Plan	0278
Cigna Healthcare of California, Inc.	0152
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Concentrated Care, Inc.	0360
Contra Costa Health Plan	0054
FPA Medical Management of California, Inc	0350
Great American Health Plan	0327
Greater Pacific HMO Inc	0317
HAI	0292
Healthmax America	0277
Health Net	0300
Health Plan of America (HPA)	0126
Health Plan of the Redwoods	0159

Heritage Provider Network, Inc.	0357
Inland Empire Health Plan	0346
Inter Valley Health Plan	0151
Kaiser Foundation Added Choice Health Plan	0289
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems Inc	0335
Key Health Plan of California	0343
Lifeguard, Inc.	0142
LA Care Health Plan	0355
Managed Health Network	0196
Maxicare	0002
MCC Behavioral Care of California, Inc.	0298
MedPartners Provider Network, Inc.	0345
Metrahealthcare Plan	0266
Merit Behavioral Care of California, Inc.	0288
Monarch Plan Inc.	0270
National Health Plans	0222
National HMO	0222
Occupational Health Services (OHS)	0235
Omni Healthcare, Inc.	0238
One Health Plan of California Inc.	0325
Pacificare Behavioral Health of California Inc.	0301
Pacificare of California	0126
Priorityplus of California	0237
Prucare Plus	0296
Qualmed Plans for Health	0300
Regents of the University of California	0354
San Francisco Health Plan	0349
Santa Clara County Family Health Plan	0351
Secure Horizons	0126
Sharp Health Plan	0310
Smartcare Health Plan	0212
The Health Plan of San Joaquin	0338
Tower Health Service	0324
UHC Healthcare	0266
UHP Healthcare	0008
Universal Care	0209
Valley Health Plan	0236
Value Behavioral Health of California, Inc.	0293
Ventura County Healthcare Plan	0344
Vista Behavioral Health Plan	0102
Western Health Advantage	0348

Other	8000

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers:
For use with discharges occurring in 1999

Name of Medi-Cal County Organized Health System	Plan Code Numbers
Cal Optima (Orange County)	9030
Health Plan of San Mateo (San Mateo County)	9041
Santa Barbara Health Authority (Santa Barbara County)	9042
Santa Cruz County Health Options (Santa Cruz County)	9044
Solano Partnership Health Plan (Solano County)	9048

(B) For discharges occurring on or after January 1, 2000, report the names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (a)(2)(A) of this section, report the plan code number representing the name of the Knox-Keene licensed plan as shown in Table 1. or the Medi-Cal County Organized Health System as shown in Table 2.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers:
For use with discharges occurring in 2000

Plan Code Names	Plan Code Numbers
Aetna Health Plans of California, Inc.	0176
Alameda Alliance for Health	0328
Blue Cross of California	0303
Blue Shield of California	0043
BPS HMO	0314
Calaveras Provider Network	0365
Care 1st Health Plan	0326
Cedars-Sinai Provider Plan, LLC	0366
Chinese Community Health Plan	0278
Cigna Healthcare of California, Inc.	0152
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Concentrated Care, Inc.	0360
Contra Costa Health Plan	0054
FPA Medical Management of California, Inc	0350
Great American Health Plan	0327
Greater Pacific HMO Inc	0317
HAI, Hai-Ca	0292
Healthmax America	0277
Health Net	0300
Health Plan of America (HPA)	0126

Health Plan of the Redwoods	0159
Health Plan of San Mateo *Healthy Families, not COHS*	0358
Heritage Provider Network, Inc.	0357
Holman Professional Counseling Centers	0231
Inland Empire Health Plan	0346
Inter Valley Health Plan	0151
Kaiser Foundation Added Choice Health Plan	0289
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems Inc	0335
Key Health Plan of California	0343
Key HMO Key Choice	0343
Lifeguard, Inc.	0142
LA Care Health Plan	0355
Managed Health Network	0196
Maxicare	0002
MCC Behavioral Care of California, Inc.	0298
MedPartners Provider Network, Inc.	0345
Metrahealth Care Plan	0266
Merit Behavioral Care of California, Inc.	0288
Molina	0322
National Health Plans	0222
National HMO	0222
Omni Healthcare, Inc.	0238
One Health Plan of California Inc.	0325
On Lok Senior Health Services	0385
Pacificare Behavioral Health of California Inc.	0301
Pacificare of California	0126
Primecare Medical Network, Inc. A CA. Corp.	0367
Priorityplus of California	0237
Prucare Plus	0296
Qualmed Plans for Health/Bridgeway	0300
Regents of the University of California	0354
San Francisco Health Plan	0349
Santa Clara Family Health Plan	0351
Scripps Clinic Health Plan Services, Inc.	0377
Secure Horizons	0126
Sharp Health Plan	0310
Simnsa Health Care	0393
Sistemas Medicos Nacionales, S.A. De C.V.	0393
Smartcare Health Plan	0212
The Health Plan of San Joaquin	0338
Thipa Management Consultants, Incorporated	0363

Tower Health Service	0324
UHC Healthcare	0266
UHP Healthcare	0008
Universal Care	0209
Valley Health Plan	0236
Value Behavioral Health & American Psychol.	0293
Ventura County Health Care Plan	0344
Vista Behavioral Health Plan	0102
Western Health Advantage	0348
Other	8000

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers
for use with discharges occurring in 2000

Name of Medi-Cal County Organized Health System	Plan Code Numbers
Cal Optima (Orange County)	9030
Health Plan of San Mateo (San Mateo County)	9041
Santa Barbara Health Authority (Santa Barbara County)	9042
Central Coast Alliance For Health (Santa Cruz County)	9044
Solano Partnership Health Plan (Solano County)	9048

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97233. Definition of Data Element—Prehospital Care and Resuscitation.

Effective with discharges on or after January 1, 1999, information about resuscitation orders in a patient's current medical record shall be reported as follows:

(a) Yes, a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital.

(b) No, a DNR order was not written at the time of or within the first 24 hours of the patient's admission to the hospital.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97239. Hospital Identification Number.

Effective with discharges on or after January 1, 1995, the last six digits of the 9-digit identification number assigned by the Office shall be reported as part of each patient record, either in the specified section of the Manual Abstract Reporting Form (OSHPD 1370) or in positions 2 through 7 on

computer media format.

Authority: Section 128765, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97240. Request for Modifications to the California Hospital Discharge Data Set.

(a) Hospitals may file a request with the Office for modifications to the California Hospital Discharge Data Set. The modification request must be supported by a detailed justification of the hardship that full reporting of discharge data would have on the hospital; an explanation of attempts to meet discharge data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each hospital with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to discharge data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed healthcare decisions.

(2) The modification would not deprive the public of discharge data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735 and 128760, Health and Safety Code.

97241. Requests for Extension of Time to File Discharge Data.

Extensions are available to hospitals that are unable to complete their submission of discharge data reports by the due date prescribed in Section 97211. A maximum of 60 days is allowed for all extensions, corrections, and resubmittals. Hospitals are encouraged to file extension requests as soon as it is apparent that the required data will not be completed for submission on or before their due date. The request for extension shall be postmarked on or before the required due date of the discharge data report and supported by a letter of justification that may provide good and sufficient cause for the approval of the extension request. To provide the Office a basis to determine good and sufficient cause, the letter of justification shall include a factual statement indicating:

(1) the actions taken by the hospital to produce the discharge data report by the required deadline;

(2) those factors that prevent completion of the discharge data report by the deadline; and

(3) those actions and the time (days) needed to accommodate those factors.

The Office shall respond within 10 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. If disapproved, the Office shall set forth the basis for a denial in a notice to the hospital sent by certified mail. The Office may seek additional information from the requesting hospital. The Office shall not grant extensions that exceed an accumulated total of 60 days for all extensions and corrections of discharge data. If a hospital submits the discharge data report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A hospital that wishes to contest any decision of the Office shall have the right to appeal, pursuant to Section 97052.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97242. Error Tolerance Levels.

(a) The error tolerance levels for discharge data items reported to the Office shall be as shown in Table 1. An error percentage that exceeds a specified error tolerance level shall be corrected by the hospital to the specified tolerance level.

(b) For error percentages for the data elements Admission Date and Discharge Date that do not exceed the error tolerance levels specified in Table 1, the Office shall delete each record with an error in one of these data elements from the hospital's report if the hospital fails to correct the data after a 30 calendar day notification by the Office of the errors.

(c) Effective with discharges occurring on or after July 1, 1990, for error percentages for data elements other than Admission Date and Discharge Date that do not exceed the error tolerance levels specified in Table 1, the Office shall assign default values of blank, which may be represented by a zero, except that for the data element Whether the Condition was Present at Admission for the Principal Diagnosis the Office shall assign the default value of Yes, if the hospital fails to correct the data after a 30 calendar day notification by the Office of the errors.

Table 1. Discharge Data Error Tolerance Levels

Data Element	Error Tolerance Level
Date of Birth	.1%
Sex	.1%
Race	5%
ZIP Code	5%
Patient Social Security Number	.1%
Admission Date	.1%
Source of Admission	5%
Type of Admission	5%
Discharge Date	.1%
Principal Diagnosis	.1%
Condition Present at Admission for Principal Diagnosis	.1%
Other Diagnoses	.1%
Condition Present at Admission for Other Diagnoses	.1%
External Cause of Injury	.1%
Principal Procedure	.1%
Principal Procedure Date	1%
Other Procedures	.1%
Other Procedures Dates	1%
Total Charges	.1%
Disposition of Patient	1%
Expected Source of Payment	.1%
Prehospital Care and Resuscitation	.1%

(d)(1) The error percentage for the data element Sex shall include unknown sex.

(2) The error percentage for the data element Race shall include unknown race.

(3) The error percentage for the data element ZIP Code shall include partial and unknown ZIP codes.

(4) The error percentage for the data element Type of Admission shall include unknown type of admission.

(5) The error percentages for the data elements Principal Diagnosis and Other Diagnoses shall, for any one record, count all errors made in coding diagnoses as one error.

(6) The error percentages for the data elements Condition Present at Admission for Principal Diagnosis and Condition Present at Admission for Other Diagnoses shall, for any one record, count all errors made as one error.

(7) The error percentages for the data elements Principal Procedure and Other Procedures shall, for any one record, count all errors made in coding procedures as one error.

(8) The error percentages for the data elements Principal Procedure Date and Other Procedures Dates shall, for any one record, count all errors made as one error.

(9) The error percentage for the data element External Cause of Injury shall, for any one record, count all errors made in coding diagnoses as one error.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97243. Acceptance Criteria.

(a) The discharge data report shall not be accepted but shall be rejected and returned to the hospital by the Office if the following requirements are not met:

(1) Submission of a completed transmittal form with the discharge data report, pursuant to Section 97214.

(2) Compliance with the Office's standard format and specifications, demonstrated by the hospital or its designated agent having previously submitted a set of data that the Office approved as being in conformance to the applicable standard format and specifications, pursuant to Section 97215.

(3) Submission of the appropriate version of the Manual Abstract Reporting Form (OSHPD 1370), as specified in Section 97215, when reporting other than on computer media.

(4) Submission by the hospital or by its designated agent in accordance with the most recent designation furnished by the hospital to the Office, pursuant to Section 97210.

(b) After a discharge data report is accepted, the hospital may be required to correct and/or replace the data if any of the following circumstances pertain:

(1) The Office is unable to read the computer media submitted.

(2) When the computer medium data file is read, it contains no data, contains data not covering the full reporting period, or contains a different number of records in the file than the number of records stated on the transmittal form.

(3) The data are not reported in compliance with Section 97215.

(4) The hospital identification number on each of the records being reported for the hospital does not agree with that hospital's identification number specified on the transmittal form, pursuant to Section 97214.

(5) Corrections are required as a result of not meeting the requirements of Section 97213; not meeting the data element definitions, as specified in Sections 97216 through 97233; and/or not meeting the error tolerance levels, as specified in Table 1 of Section 97242.

(6) All inpatient discharges, as defined by Subsection (d) of Section 97212, were not reported.

(c) If a hospital is required to replace or correct their discharge data, the Office shall allow a specified number of days for correction or replacement and shall establish a due date for resubmittal of the corrections or replacement. In determining the number of days to be allowed, the Office shall take account of the number and degree of errors and the number of extension days already granted, but in no case shall an aggregate total of more than 60 days for all extensions, corrections, replacements, and resubmittals be allowed.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

APPENDIX F

FORMS

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PATIENT DISCHARGE DATA PROGRAM
MANUAL ABSTRACT REPORTING FORM

For use with discharges on or after January 1, 2000

Instructions: For a description of the data elements, refer to the appropriate section of Discharge Data Regulations (Sections 97210 through 97239, Title 22, California Code of Regulations).

1. TYPE OF CARE

1 Acute
3 SN/IC
4 Psychiatric
5 Chem Dep
6 Physical Rehab

1a. HOSPITAL ID NUMBER

17. ABSTRACT RECORD NUMBER (Optional)

2. DATE OF BIRTH

Month | Day | Year (4 - Digit)

20. PATIENT'S SOCIAL SECURITY NUMBER

(000 00 0001 If not recorded in the medical record)

3. SEX

1 Male
2 Female
3 Other
4 Unknown

4. RACE

ETHNICITY
1 Hispanic
2 Non-Hispanic
3 Unknown

RACE
1 White
2 Black
3 Native American/ Eskimo/Aleut
4 Asian/Pacific Islander
5 Other
6 Unknown

5. ZIP CODE

6. ADMISSION DATE

Month | Day | Year (4 - Digit)

9. DISCHARGE DATE

Month | Day | Year (4 - Digit)

16. TOTAL CHARGES

(Report whole dollars only, right justified)

7. SOURCE OF ADMISSION

SITE
1 Home
2 Residential Care Facility
3 Ambulatory Surgery
4 SN/IC
5 Acute Inpatient Hospital Care
6 Other Inpatient Hospital Care
7 Newborn
8 Prison/Jail
9 Other

LICENSURE OF SITE
1 This Hospital
2 Another Hospital
3 Not a Hospital

ROUTE
1 Your ER
2 Not Your ER (or no ER)

8. TYPE OF ADMISSION

1 Scheduled
2 Unscheduled
3 Infant, under 24 hrs old
4 Unknown

15. EXPECTED SOURCE OF PAYMENT

PAYER CATEGORY
01 Medicare
02 Medi-Cal
03 Private Coverage
04 Workers' Compensation
05 County Indigent Programs
06 Other Government
07 Other Indigent
08 Self Pay
09 Other Payer

TYPE OF COVERAGE
1 Managed Care - Knox - Keene/ MCOHS
2 Managed Care - Other
3 Traditional Coverage

NAME OF PLAN

(0001 - 9999 Plan Number)

14. DISPOSITION OF PATIENT

01 Routine (Home)
Within This Hospital
02 Acute Care
03 Other Care
04 SN/IC
To Another Hospital
05 Acute Care
06 Other Care (Not SN/IC)
07 SN/IC
08 Residential Care Facility
09 Prison/Jail
10 Against Medical Advice
11 Died
12 Home Health Service
13 Other

21. PREHOSPITAL CARE AND RESUSCITATION

DNR order written at the time of or within the first 24 hrs of admission

Y = Yes
N = No

E - CODES

18. PRINCIPAL E

19. OTHER E E E E

Be sure page 2 is copied on the reverse side!

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PATIENT DISCHARGE DATA PROGRAM
SUPPLEMENTAL REPORTING PAGE

For use with discharges on or after January 1, 2000

10. PRINCIPAL DIAGNOSIS

CODE

10a. PRESENT AT ADMISSION

Y = Yes
N = No
U = Uncertain

11. OTHER DIAGNOSES

11a. PRESENT AT ADMISSION

a.		a.
b.		b.
c.		c.
d.		d.
e.		e.
f.		f.
g.		g.
h.		h.
i.		i.
j.		j.
k.		k.
l.		l.
m.		m.
n.		n.
o.		o.
p.		p.
q.		q.
r.		r.
s.		s.
t.		t.
u.		u.
v.		v.
w.		w.
x.		x.

Y = Yes
N = No
U = Uncertain

12. PRINCIPAL PROCEDURE

CODE

DATE

Month | Day | Year (4 - Digit)

13. OTHER PROCEDURES

a.		a.
b.		b.
c.		c.
d.		d.
e.		e.
f.		f.
g.		g.
h.		h.
i.		i.
j.		j.
k.		k.
l.		l.
m.		m.
n.		n.
o.		o.
p.		p.
q.		q.
r.		r.
s.		s.
t.		t.

Month | Day | *Year (4 - Digit)*

Be sure page 1 is copied on the reverse side!

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DISCHARGE DATA

INDIVIDUAL HOSPITAL TRANSMITTAL FORM

OSHPD Use Only
PM Date: _____
Batch: _____
Agent: _____

Hospital Name: _____

Hospital Identification Number: | | | | | | |

Report Period From: _____ to _____

Total Number of Records: _____

MAGNETIC TAPE

( ) 9 track, 1,600 BPI ( ) 9 track, 6,250 BPI

( ) IBM Standard Labels ( ) Unlabeled

( ) EBCDIC ( ) ASCII

( ) IBM 3480 Compatible Cartridge

BLOCK SIZE: _____

DISKETTE

( ) 5¼" Diskette

( ) 3½" Diskette

( ) CD-ROM

Filename:

_____

CERTIFICATION

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly authorized to sign
(Name of Hospital)

this certification; and that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ By: _____
(Signature)

Hospital: _____ Name: _____
(Please Print)

Address: _____ Title: _____

_____ Phone: _____

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DISCHARGE DATA

AGENT'S TRANSMITTAL FORM

OSHPD Use Only

PM Date: _____

Batch: _____

Agent: _____

Agent's Name: _____

Contact Person: _____ Title: _____

Address: _____

Phone No: ( ) _____ Ext: _____

MAGNETIC TAPE

( ) 9 track, 1,600 BPI ( ) 9 track, 6,250 BPI

( ) IBM Standard Labels ( ) Unlabeled

( ) EBCDIC ( ) ASCII

( ) IBM 3480 Compatible Cartridge

BLOCK SIZE: _____

DISKETTE

( ) 5¼" Diskette

( ) 3½ Diskette

( ) CD-ROM

Filename:

_____

	HOSPITAL NAME	HOSP IDENT NO	REPORT PERIOD BEGINNING	REPORT PERIOD ENDING	TOTAL NO OF RECORDS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PATIENT DISCHARGE DATA

DISCHARGE DATA CERTIFICATION FORM

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly authorized to
(Name of Hospital)

sign this certification; and that, to the extent of my knowledge and information, the discharge abstract data records submitted to _____ for the period
(Name of My Hospital's Designated Agent)

from _____ to _____ are true and correct, and that the definitions
(Starting Date) (Ending Date)

of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated:_____

_____
(Name of Hospital)

Hospital Identification No: | | | | | | |

Name: _____
(Signature)

Name: _____
(Please Print)

Title: _____

Address: _____

_____

Phone: _____

DISCHARGE DATA DISCLOSURE REPORTING
EXTENSION REQUEST

To: Office of Statewide Health Planning and Development
Healthcare Information Division
818 K Street, Room 100
Sacramento, CA 95814
(916) 323-7679
Fax No. (916) 322-9555
Fax No. (916) 327-1262

Date: _____

ATTN: Patient Discharge Data Section

1. Hospital Name (DBA): _____
2. Address: _____
3. Mailing Address (if different): _____
4. Hospital Identification Number: _____
5. Report Period Beginning Date: _____
6. Report Period Ending Date: _____
7. Designated Agent (if applicable): _____
8. Number of Days of Extension Request: _____
9. Justification: (Include actions taken to produce the data by the required deadline, and factors that prevent submission of the data by the deadline, and actions to be taken and the time needed to accommodate them):

_____

_____

_____

_____

_____

_____

10. Person Requesting Extension (print): _____
11. Signature: _____
12. Title: _____
13. Phone: _____

APPENDIX G

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